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EVOLUTION OF OUR TREATMENT PHILOSOPHY IN CHILD GUIDANCE *

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TREATMENT in the field of child guidance is a subject upon which there has been a great deal of thinking, but relatively little writing. More definite formulation of our objectives, and of the steps by which we have reached our present position, seems to be desirable in order to clarify some of the purposes that we are all striving to achieve.

There are certain factors in treatment that are relatively stable and that can be disposed of at the outset of this paper, not because they are unimportant, but because opinion about them is rather unanimous. Care of the physical health of the child has always played a prominent rôle in mental-hygiene therapy, and there always will be the desire to give adequate attention to remedial physical conditions. There is a slight danger that these more tangible factors may be relegated to the background in our interest in understanding the interplay of those emotional factors which frequently are of more importance. It is only necessary to mention at the outset the important part that sound physical health plays in the field of behavior, and to state that the establishment of it in the individual case will always be an important objective in our therapy.

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But there can be no doubt that our major objectives have to do with understanding those human relationships that revolve around the growing personality of the child and modifying those that seem to be placing barriers in the way of a healthy achievement of maturity. It is in this field that the most important advances in our therapeutic endeavors have been made.

Dynamic psychiatry has gone through an interesting cycle, beginning with an interest in unraveling the genetic history of adult reactions, which in turn led to a greater focusing on the child, with the idea of studying and preventing those adult problems in their incipient stages. And now we find ourselves going back to a more careful consideration of those adult reactions which are so important in shaping the personalities of children. The understanding and modification of such adult problems has become the focus of our therapeutic endeavors in the field of child guidance. Reaching this stage has been an interesting and difficult process, as it has meant going against very definite and almost universal trends in the adult-child relationship—and against common practice in most community organizations that deal with problem behavior.

In dealing with child behavior, the major objective has been—and still is, to a large extent—the eradication of that behavior which is considered undesirable. If a child is stealing or playing truant or is fearful or lying, the efforts of the adult world, more particularly in home, court, and school, have been to eliminate the behavior that causes deviation—and to do this by attempting to change the child. The most common approach has been either on a moralizing or a reasoning basis, an attempt to convince the child of the undesirability of a certain type of behavior, or attention has been given only to the more extrinsic factors of the environment—the gang, the neighborhood, housing, economic factors, and the like—and to supplying more wholesome outlets to replace less desirable ones. The punishment motive has been a part of the moralizing approach, and naturally follows as a stronger incentive when the child fails to respond and does not conform to the adult code.

In both of these approaches, it is the behavior of the child

that is directly attacked. Emotional factors in the relationships between child and adult have not been touched upon, but emphasis has been placed upon the more superficial aspects of the situation. It is obvious that treatment can remain on that level only because it is dealing merely with the symptoms on a subjective plane and because the more basic causal factors are neither understood nor treated.

The desire for a more fundamental understanding of causal factors in the child's behavior has resulted in a long step forward to a more intelligent dealing with matters aside from, but related to, the behavior of the child. But a dynamic interpretation of behavior has not always been followed by a dynamic type of treatment. Clinics with a good understanding of causal factors have found it a matter of considerable difficulty to get away from the rather primitive eradication objective. Attention has continued to revolve very largely around what the child is doing, and our therapeutic urge has led us to adopt, in a great many instances, a treatment program based upon the specific-suggestion type of therapy, which might be termed the old moralizing type of approach disguised in a little more modern type of dress. Sound interpretation based on known facts has not always been carried over into treatment, and it is this further step that we are now trying to work out.

The demands of the moment frequently force a psychiatrist or a social worker to adopt the specific-suggestion type of approach. A distraught parent faced with an acute problem demands prompt relief. If her young child will not eat, she requests specific directions as to what to do. The question, "What shall I do?" becomes the focus of the whole study, and our desire to maintain a good contact and our own therapeutic urge lead to the adoption of this approach even when we know that in giving such advice we are helping to gloss over a more fundamental problem that study has revealed to be the real source of the child's difficulty. These suggestions of ours are tried out; usually they have been tried out before and have been read about in the flood of literature that deals with habit training on just such a level. Usually they fail, and every psychiatrist and social worker in this field knows the sense of futility that results when one has exhausted

all one's pet suggestions without solving the problem, and the parent returns for further instructions.

Here is an example that probably can be duplicated in the files of every clinic and in the experience of all those working in this field. A child of five was referred by anxious parents because of fears and temper outbursts and poor eating and sleeping habits. At the time of the original study, there was a fairly good understanding of a very difficult situation in the parents' own lives, involving economic factors, a marked sensitiveness about racial and social status, and a very critical attitude toward them by their own families, who had attained a better all-around adjustment. The importance of these things as they affected the child were recognized, and yet the treatment program was largely focused on the behavior of the child. The parents were given a careful interpretation of this behavior—were shown how a great deal of it was based on a desire for attention—and specific suggestions were then outlined as to how to deal with the difficulties. A really dynamic interest was lost in the static attempt to change the behavior. Detailed directions were given as to the best way to get the child to eat and how to deal with the tantrums, the best types of discipline, and so forth. There was nothing wrong with the instructions; they conformed to the accepted standards on this habit-training level. The child was worked with directly by the use of star charts and other paraphernalia, but little progress was made because the fundamental problem in the adult life of the parents was left untouched. Two years later we had to start over again, as the problem remained unchanged.

This desire to change behavior by working rather directly with the child—either by means of star charts, systems of rewards, or semi-moralizing—and working with the parent on a habit-training basis marked a great deal of our earlier treatment philosophy. Lately there has been developing a feeling of its futility and of the need for a more direct approach to the fundamental factors in the relationships of the home.

One of the unhealthy features of this focusing on changing the behavior of the child by direct, but superficial means is that it has provided the adults with another excuse for avoid-

ing the necessity of facing those problems of their own which bear a causal relationship to the behavior of the child. It overlooks a fundamental principle in modern psychiatry—namely, that behavior is reactive and adaptive and expresses the way in which the individual is meeting a situation. It does not seem sound, therefore, to attempt to change the behavior without altering the factors that have contributed to its development. That is exactly what we attempt to do when we allow ourselves to be pushed onto a specific-suggestion level. To keep away from this level is one of the most difficult tasks that confronts the psychiatrist and the social worker in the field of child guidance, and to do it means that there must be a rather clear objective in their relationships with parents from the very outset.

The mere alteration of a child's behavior does not always mean that therapy has been successful. This fact is well illustrated by the following case. An attractive German girl of good intelligence was running away from home at very frequent intervals. The home presented a picture of a very autocratic father who ruled the family with an iron hand, particularly this girl. A great deal of work was done with the girl, both in the clinic and outside in the way of providing more satisfying outlets in the form of dancing classes, Girl Scouts, and so forth, and enlisting the interest of teachers. The direct work with the father consisted mainly in telling him what he was not allowed to do to his family in this country. Partly as a result of our interest and efforts, the running away stopped, but the home condition remained unchanged. In place of the running away there was substituted a cynical, resigned, and withdrawn attitude, which we all felt was a more serious reaction than the more natural running away. The behavior of this child was a very inaccurate measure of treatment results and is a clear illustration of the direction in which a wrong objective in therapy can lead us. I am inclined to feel that an approach based upon this type of therapeutic objective frequently does more harm than good when the problem really arises out of much more fundamental difficulties in adult living. When it does *not* arise on such a basis, then it is not very much of a problem, and some of the petty irritations in the parent-child relation-

ship might be ironed out on this superficial level. What the psychiatrist and social worker can do in such instances is to restore or strengthen the confidence of the parents in their ability to work out the details of their relationship with their children without giving them a card-index type of instruction which tells them "what to do if my child does this or that". There has been too much of that type of guidance and spoon feeding of parents, not only in clinics, but in some types of parent education and in a great deal of the literature on child psychology.

Our treatment philosophy seems to be swinging away from the child in the direction of working out with parents and other adults their own problems, which cause them to adopt an attitude toward the child that produces a disturbance in the growing-up process. The establishment of such a relationship between clinic and parent presents a problem in technique and tact and understanding that is the most difficult thing confronting us in this field at the present time.

A direct approach to a parent can be on a constructive basis only if it recognizes that parental attitudes have a genetic history and therefore a reason for existing. Too frequently we have an appreciation of the genetic history of a child's behavior and see the effects of a destructive attitude on the part of the parent and yet fail to recognize that it, too, has a background that must be worked out if a real change is to be effected. The direct approach to an adult, if it is really to be effective, must be on an understanding level and not on one that seeks only to point out his mistakes and thus increases his sense of failure. There is a great deal of this type of direct dealing with adults, particularly in courts and schools, the destructive effect of which is apparent.

A fairly direct and sympathetic working out with the adults of their own attitudes and relationships—not only with the child, but with other adults, particularly those in their marital and family situations—seems the objective toward which we are working in the field of child guidance.

The method of doing this is important. The important thing seems to be not to give parents an interpretation of the

situation that a staff has worked out, but rather to utilize this interpretation as a means of getting them to discuss and work out important factors themselves, and to give them insight only as it seems to fit in with what they have been able to work out and accept. It is quite possible to work on this direct level with parents without arousing defensive reactions and irritability. Where such reactions are aroused, it is a certain indication that you are speeding up matters and going beyond the capacity that they have developed to apply the changed attitudes in their daily relationships. A type of rapport can be developed between worker and parents that will give them the sense of a joint interest and responsibility in working out the solution of the problem, instead of a relationship in which the parents are told what to do and why certain things have been done in the past. The more connections that you can get the parents to make themselves, the more successful will be the treatment. The fewer specific suggestions given to them for handling this or that type of child reaction, the easier it will be to reëstablish their confidence in themselves and their own maturity, so that they will feel able to decide those specific points themselves. There is a direct relationship between the amount of specific advice that parents want on how to handle the daily problems of their child and the degree of confidence and balance that they have been able to establish in their own problems and relationships. Help them to attain such confidence and they will not be so fearful of making a mistake once in a while.

A question arises as to the value of working directly with the *young* child when the major factors are known to lie in the parental attitudes. There is no question that a great deal can be learned about the working of the child mind and material can be gained that can be given to parents to help them to a better appreciation of the effect of their own attitudes on the child. The chief difficulty in working directly with a child is that it frequently helps the parents to avoid facing the major issues involved by giving them the feeling that the psychiatrist, because he is doing a lot of direct work with the child, also feels that the changing of the child

in some manner really is the most important thing. When work is done with the young child as a part of the treatment, it is safer to let the parent know that such efforts are only a step in helping them to a clearer understanding of the total situation.

Often direct work with the child is essential in order to build up a good working relationship with a defensive parent, so that a more direct approach to his own problems may later be made. As an example of this, we recently studied a nine-year-old boy who had been stealing. The father was a very aggressive, domineering German whose whole conception of his relation with the boy was to force him to a rigid standard of discipline, to plan his every move, to restrict his interests, and to expect a high standard of performance that would be satisfying to the father's own unsatisfactory attitude toward himself. A direct attack on this deeply ingrained philosophy—which grew partly out a very Spartan relation with his own father, in whose methods he had absolute faith—would have been futile. And yet he was interested enough to bring this boy to the clinic and ask us to find out why he was stealing. But he wanted us to find the reason in the boy, not in the boy's relationship with his father. In this case, it seemed to us that a certain amount of direct work with the boy was necessary while we were gradually shifting attention to the needs of a growing boy in the way of more freedom of thought and action, and attempting to change the father's future relation with the boy. In time it might be possible to help him see the destructive effect of his iron-clad methods, but to have done it at the outset would have resulted in severing his relations with the clinic.

If we keep in the foreground of our thinking what our treatment objective really is, even though for reasons of expediency we may have to postpone the carrying of it out, it would seem that we are on fairly safe ground. However, I am inclined to feel that we have been led into an expedient type of treatment philosophy by being somewhat over-cautious about approaching rather early in the case the adult problems involved, and so remaining too long on a specific-suggestion level.

There is one factor in treatment that must always be watched, particularly with students or those whose experience is being formed—and that is the tendency to identify oneself in a rather subjective way with certain persons in the case. We had been working with the mother of a very difficult problem boy, and the psychiatrist had been attempting in many interviews to give this mother an interpretation of why the boy was doing certain things. One day the mother remarked with some anger, "You never see anything wrong with that boy." Suddenly the psychiatrist realized what he had been doing. He had identified himself with the boy and in so doing had placed himself in the rôle of a critic, and the mother reacted to him just as she did to the boy.

The capacity to be objective with all the individuals in a situation and still give them the feeling that you are sympathetic and anxious to understand their point of view, and to maintain that relationship in an atmosphere of tension and friction, is possibly one of the superhuman tasks that we ask of social workers and psychiatrists in this field. Yet successful therapy in reintegrating those human relationships that affect the behavior of a child is dependent very largely on one's capacity to reach this goal.

It seems certain to me that we cannot split treatment up into artificial and meaningless compartments. The fourfold type of study that has been of so much value in the child-guidance clinic has led to the temptation to do this very thing—to think in terms of social treatment, psychiatric treatment, and so forth. Such a conception of the individual is quite out of keeping with the broad, integrated concept which sees the individual reacting to and in turn reacting upon a set of conditions. These two things cannot be dissociated.

The smoothing out of this artificial distinction between the social and the psychiatric aspects of a case has contributed to a clearer realization of the essential similarities in the various fields of social work that deal with human relationships, and of the fact that the treatment approach to a problem is much the same whether the entering wedge is the child or an alcoholic father. There is probably still some disagreement on this point, but progress seems to be ironing

out these differences and helping to clarify the essential treatment objectives in the various fields.

Some of our therapy has led to a certain subjective feeling of hopelessness, because of a tendency to set up rather idealistic standards for all of our cases. When there is a good objective grasp of the total situation, a plan will follow which recognizes that certain features can be improved while others must be accepted as relatively fixed. Our treatment objectives must be individualized, with a relative sense of proportion as to what can and what cannot be accomplished. A feeling of hopelessness in any situation is a subjective emotional reaction on the part of the worker, usually based upon a sense of her own inability to adjust her therapeutic expectations to the accomplishments possible in a given situation. Students find this the hardest point of view to incorporate into their treatment philosophy, particularly if their training has been on a very intensive basis on a small number of cases. Perspective comes from seeing the possibilities in a fairly wide variety of problems and from the opportunity to work along with a situation over a period of time.

CONCLUSION

In conclusion, it seems that a great deal of progress has already been made in our point of view on child behavior and in the formulation of a therapeutic philosophy that will lead to a more wholesome relationship between child and adult. The extent of our progress can be measured by the degree to which we have grown away from a primitive, eradication type of objective, which saw only the child's behavior and sought to correct it. Progress in the future will depend upon our ability to develop this point of view in all the community agencies that deal with the child, particularly the child who has deviated from socially acceptable forms of behavior. This objective is the foundation of modern psychiatry, and it is interesting to note that as far back as 1908 Dr. Meyer made this statement: "Achievement [in the field of prevention] will come less as the result of attempts at eradication than through the more rational method of furnishing such

timely protection and balancing material as will make dangerous tendencies harmless."[1]

The balancing material in the therapeutic philosophy of child guidance seems to be the creation of a better balance and a more rational understanding of the problems of adult living. This approach, affecting as it will the important attitudes that adults take toward the child, will make many dangerous or unhealthy tendencies not only harmless, but unnecessary.

[1] "What Do Histories of Cases of Insanity Teach Us Concerning Preventive Mental Hygiene During the Years of School Life?", by Adolf Meyer, M.D. *The Psychological Clinic*, June 15, 1908. pp. 95–6.

THE UPPER FIFTH

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SUNDAY supplements have done their part in making the proletariat suffer from the virus of the green-eyed monster. Minnie, spending her days in the nether regions of another woman's house as the washer of innumerable pieces of soiled linen, in the kitchen with equally hopeless stacks of dishes, or in the nursery trying to make fit for the public eye bedraggled Jane and John, goes wandering off into daydreams when confronted by the rotogravure (covering an entire sheet) of the week-end guests of Mrs. Schyler Van Zoil disporting themselves in a green marble pool on a Long Island estate. Tucked away in an obscure corner of the same generous special Sunday section, the small likeness of Marcus Aurelius Smith, A.B., M.A., Ph.D., discover of the Beta ray, entirely escapes her notice, although this same Beta ray may at some future date be the means of saving her miserable, grubby little life. So much for our sense of values.

The masses are obsessed by unfulfilled desires concerned with Society's Four Hundred. It is just as well that aspirations to belong to the "Upper Fifth" in the sphere of intelligence are not so common; for by certain fortuitous turns of fortune's wheel chorus girls have been known to attain a place in that same Four Hundred, but it would be as easy for the alchemist to turn lead into gold as it would for Alfred, a moron who sells dill pickles across the counter at Schwartz's Delicatessen, to enter into the world of Marcus Aurelius Smith.

When everything is said and done, the world could wag along fairly comfortably without the Schyler Van Zoils, but it would still be using stone axes and dying of plagues without the Marcus Aurelius Smiths.

All this by way of preamble.

Among the social agencies that are supported by the Com-

munity Fund of Cleveland, Ohio, is the Women's Protective Association, an organization whose work is highly specialized, dealing as it does with the problems of adolescent girls—that is to say, with girls between twelve and twenty-one who have for some reason found themselves at odds with the social milieu in which they live. Recognizing early that any problem of an individual represents causal factors rooted in the individual acting upon and being acted upon by the social situation, the association felt that psychological study of the girl was an indispensable part of any scientific program of treatment. Consequently, in 1921 there was put into effect a program which called for such a study in every case that seemed in any way to require it. While it would doubtless be desirable to make this intensive study of every case handled, certain factors, such as the time involved and the difficulty frequently encountered in getting girls into the clinic, make such a program manifestly impossible.

Stanford-Binet intelligence tests have been given to 3,164 girls referred to the organization since 1921. It is on the basis of the results of these tests that the present study was made. While this test did not by any means represent the entire psychological program, it is the only one that was used in every case. The writer holds no brief for any particular test or tests and is cognizant of the limitations of such psychological instruments, but the results of even one such test, when used in thousands of cases and over a period of years, are significant. They afford us the opportunity of comparing at least one facet of that oddly constructed and elusive thing we dub "personality".

At the outset let us concede that, whatever the reason, there is no such thing as equality in this matter of intelligence, specifically verbal intelligence. The thing is obvious. An adult who does not know what copper is, who says that wool, cotton, and leather all come from the same animal, does not by any stretch of the imagination live in the same world as the individual to whom electrons and protons are something more than a jumble of letters.

It would appear that in a normal distribution of unselected individuals with regard to verbal intelligence, as measured

by the Stanford-Binet tests, we could expect approximately one-fifth, or 20 per cent, to be of superior intelligence. It is to this "Upper Fifth" that the community must look for its professional men and women, its leaders in civic and social life. Society can ill afford to let them fall by the wayside. Hewers of wood and drawers of water are plentiful. As they drop out, their ranks are filled up with scarcely a ripple. Those who are qualified through their hereditary potentiality to be leaders are comparatively scarce.

Of the 3,164 girls who came to the attention of the Women's Protective Association because of some serious maladjustment and who were given intelligence ratings on the Stanford-Binet test in the period from 1921 to 1928, only forty-seven were ranked as of superior intelligence. This number is little more than 1 per cent of the total number tested, or about one-twentieth of what could be expected in an unselected group. At this point it is significant to note that Cleveland has a very large foreign population. On the average, 67 per cent of the girls who have contact with the organization are of foreign parentage. If we could arbitrarily remove the handicap imposed by a home where the parents are foreign and speak a foreign language, it is likely that the percentage of girls ranking in the superior group would approximate much more closely the normal 20 per cent. However, if we limit ourselves to the relatively small percentage represented by the forty-seven cases, it is still significant when one remembers that practically all these girls presented some serious maladjustment.

That many of our under-endowed and under-privileged girls fail in their struggle to make satisfactory social and industrial adjustments is natural. Life is too swift and competition too keen for them. It is easy to see why the plodder or dull of wit is truant from school, becomes involved in sex difficulties, steals, lies, or is generally incorrigible, but it is by no means so easy to find extenuation for the girl of superior intelligence, for we assume as factors in high-grade intelligence a certain amount of practical judgment, ability to foresee consequences, and the power of self-criticism.

The study presented in this article was undertaken in an

attempt to analyze the cases of the forty-seven out of the total of 3,164 girls who were in the "Upper Fifth"—that is, those whose intelligence quotients on the Stanford-Binet test were 110 or above. What, if any, are the common factors in their maladjustments? To what extent was the community responsible for their deviations from desirable behavior, and to what extent was it able, through one of its social agencies, to correct conditions or disentangle personality twists to the end that these girls might make use of their potentialities?

In the first place, let us consider what the difficulties were in which the girls found themselves involved and how they came to the attention of the organization.

The problems for which they were originally referred were as follows: Seven had run away from home; four had stolen merchandise or money; three were seeking employment; two were stranded; nine were involved in serious maladjustments at home; eleven were incorrigible; six were sex delinquents; two were habitual truants from school; one was working under undesirable conditions; one sought advice about the undesirable attentions of another girl; and one desired assistance in going to college. They were referred as follows: nine by the Women's Police Bureau; seven by their families; seven by the school; five by the Y.W.C.A.; four by other social agencies; four by members of the staff; three by their employers; three by neighbors; and one by her landlady. Four came to the organization of their own volition.

As was to be expected, investigation showed that the specific problem for which the girl was originally referred was frequently merely the manifest one, and it was to the latent problems uncovered during the contact of the organization with the girl that attention had to be directed in an attempt to assist her in her efforts at a better adjustment and to find a possible predictive basis for future conduct.

Why did seven of these girls of superior intelligence run away from home? A brief analysis of these cases is instructive.

Emma, thirteen years old, with an I.Q. of 110, was brought in by the Women's Police Bureau. She had been missing from home for several days. When taken to the police sta-

tion, she absolutely refused to go home, preferring detention as the lesser of two evils. On the face of the thing, she was a stubborn, unmanageable girl who needed disciplining.

Emma was a well-developed, attractive, vivacious Italian girl, mature for her years. The father was dead, and the mother worked away from home, leaving Emma without supervision all day and with the responsibility of bossing two recalcitrant younger brothers. The neighbors began to gossip about her because of her short skirts, flashy cosmetics, and her general "smart-aleck" air. Being good Italians, they thought that she should be getting her a husband and suggested it with disgusting frequency. The mother allied herself with her neighbors in this onslaught and began to scour the neighborhood for prospects, not being overly particular as to age or appearance. Emma resented vigorously these attempts to dictate to her. She would pick out her own husband when she got good and ready, and she would dress and make up her face to suit herself.

In addition to this home situation, she came to loggerheads with the school because she refused to take a prescribed shower bath on one occasion or to lengthen by a hair's breadth a scandalously short skirt. (Of course the teachers couldn't know that Emma had quite inadvertently taken a bigger tuck in the skirt than she had intended to take.) While nature had been lavish with Emma in the matter of color, with the gay extravagance of youth she desired to improve on it and added more rouge than the school authorities deemed artistic. Once on, she refused to take it off. The result of all this rebellion was an appearance in juvenile court and ten days in which to meditate on her sins in the detention home. This ignited a smouldering resentment against the restraints imposed by school authorities and a still deeper resentment against the efforts of her mother and the neighbors to impose upon her the Old World concepts of what a young girl ought to do and how she ought to behave. The last straw was the continual threat to marry her off willy-nilly. To this intelligent, high-spirited girl, the only solution to an intolerable situation seemed to be to run away—and this she did.

Winnie, at seventeen and with an I.Q. of 110, decided to

see the world via the "hitch-hike" route. There seemed to be nothing more serious in her case than a touch of the gypsy foot and somewhat irresponsible parents, who complacently stated that "all of their children ran away from home—but they all came back"!

Mattie, not quite sixteen, had an I.Q. of 111. Her parents had found the responsibilities of matrimony and parenthood entirely too arduous and had nonchalantly left their daughter to the mercies of an aunt and uncle. Things were not going along any too smoothly for Mattie with this aunt and uncle, and she was afraid that they would ship her back to her mother and a stepfather whom she loathed. Mattie attempted to solve her problem by running away.

Contact over some time with Mattie showed her to be decidedly unstable. She was "spoiled", given to temper tantrums, a pathological liar, a petty thief, and a sex delinquent. Once — as a gesture — she attempted suicide. This was a way of getting the attention that she craved. A tendency to run away from any situation in life that smacked of unpleasantness had become fairly firmly fixed in Mattie by the time adolescence was reached. The heredity in her case was decidedly questionable and the rearing inadequate. Her behavior is readily understandable in the light of these facts.

Joyce, at nineteen (I.Q. 112), ran away from her home in a nearby city in an attempt to forget an unhappy love affair. The boy with whom she thought herself in love had unexpectedly married another girl. It is probable that the smart of anticipated pity from friends and neighbors was as much a factor in determining her action as any real or fancied grief over the affair. Slighted love—to the adolescent—is real tragedy.

Erma, blessed with very superior intelligence (I.Q. 125), at fourteen found herself at odds with herself and her family. She quarreled with her father, her mother, and her younger sister almost continually, making herself as entirely disagreeable and unhappy as she could well be. Careful study and investigation disclosed marked psychopathic tendencies, such as enuresis, extreme irritability, and quarrelsomeness. She was markedly introverted. At the root of

her maladjustment, apparently, was a feeling of inferiority. Most of her classmates came from families whose social status was much superior to that of her own. She loved her father—an unobstrusive, conscientious little shoemaker — but she was ashamed of his foreign birth and his humble trade. She was in an advanced section in school, so that the competition was keen enough to make her uneasy about the one thing in which she had maintained superiority—her school work. She was unable to reconcile her conflicting emotions about her family and to feel security in her scholastic superiority. The psychic turmoil manifested itself in her hatefulness at home. When the pressure became too great, she attempted to run away from the whole home, school, and community situation and from herself.

Ellen, almost thirteen and with an I.Q. of 111, found herself discontented at home and disgruntled at school. She was sullen, quarrelsome, and defiant of all authority. Although not yet thirteen, she was a sex delinquent of more than three years' standing. To make her list of accomplishments complete, she was a liar, a truant from school, and dishonest.

Ellen's parents were foreign born and there was constant conflict in the home. With her intelligence, she could scarcely be expected to be complacent in the face of attempts to curb her backed up by the whip. She was unquestionably egocentric and her "will-to-power" found no outlet except in socially undesirable conduct. If one accepts the psychoanalytic point of view, it is possible that it was the thwarting of this drive that threw her into sex delinquency at the early age of ten. Her solution for her complicated problem was running away from home.

Mona, at eighteen, exhausted the Stanford-Binet test very quickly and made a score on the Army Alpha test approximately twenty points higher than that of the average university senior.

In the rush and confusion of the Christmas crowds in the station, she lost her purse. Something about her demeanor made the representative of the social agency to whom she went for help suspicious, and she was brought to the office of the organization pending an investigation. They suspected

that she was running away and, sure enough, she was—running away from the irksomeness of supervision by an officer of the state industrial school from which she had recently been paroled and from the deadly dullness of a housework job.

Mona would make most excellent material for the proponents of either side of the heredity-versus-environment controversy. Together with a brother and sister, she was abandoned at a very early age by her parents, who were obviously irresponsible and unstable. Her foster parents were a well-meaning pair; the father an indulgent, dull sort of person, a butcher by trade; the mother prim, hidebound, scrupulously religious, and deadly unimaginative. She carried out every item of what she considered to be her duty to her foster child. This duty, as she saw it, included making a moral girl of Mona by greeting every fault of the eager and alert child with the remark: "Well, what could I expect of you? Your father was a thief and your mother a prostitute." The constant suggestion had the result to be expected; in the course of time, Mona became both.

Confronted by this fact, the foster mother repudiated Mona and was instrumental in having her sent to the state industrial school, hoping thereby to salvage something of her wayward soul. The time spent there did have one good effect—Mona was found to have more than a little talent in commercial art and was encouraged by one of the instructors, so that when she came out a little more than a year later, it was with a shred of a dream that there might after all be a chance for her to do something beside wash other people's dishes. The dream all but got away from her in the face of the reality of having to make money to live on, and she found herself again doing housework. Irked beyond all endurance, she tried to run away, only to find herself face to face with the fact that it is only the rare soul that can succeed in running away from life—and the consequences of its own actions.

The term "maladjustment in the home" covers a multitude of things. An analysis of the cases of the nine girls referred for this cause discloses some significant causal factors.

Vera has an I.Q. of 112. At a little less than seventeen, she made complaints to the neighbors that her adopted mother

was brutal to her and that she could no longer live with her. A study of Vera showed that she was unreliable, untruthful, and obstinate. She had always been pampered by her foster parents, who she had discovered were not her real parents only shortly before coming to the attention of the organization. The situation was complicated by the fact that Vera was exceedingly jealous of the older girl in the family, the real child of her foster parents. The emotional conflict caused by the discovery about her parentage—and, possibly, an attempt to compensate for the feeling of inferiority generated by it—brought about such gross misbehavior on her part that the mother retaliated by a strictness she had never used before. The thing became a vicious circle. The more severe the mother became, the more recalcitrant Vera grew, until the situation became unbearable for every one concerned.

Ethel was not yet fourteen. She had an I.Q. of 113. It was too much to expect that she would tolerate the dictation of a very young stepmother who was of border-line intelligence and whose history of sex delinquency showed her instability and irresponsibility. To add to the hopelessness of the situation, the father was a thief. What could there possibly be in such a home to satisfy the eagerness of an active adolescent mind groping for mental stimulation? Ethel's stepmother complained that she could do nothing with the girl and wanted some action taken with regard to her.

Rosa, at a little past twenty-one, came to the organization seeking sanction for leaving her home. Considering her foreign background, the I.Q. of 112 is probably quite conservative. She was keen, alert, and inordinately ambitious for education, culture, and sane living. For some time she had been wavering between cutting loose from her family, which she felt was the intelligent thing to do, and an emotional reaction against such a step engendered by a rather overgrown sense of duty.

At six Rosa had lived for a brief time in a neighborhood where most of the families were American. With a keenness of observation and judgment unusual in a child of this age, she had detected the difference in the treatment accorded

women and children by these neighbors and that usual among the people of her parents. Then and there she repudiated everything in any way connected with her race. She consistently refused to learn to speak the language, in spite of the fact that she had to understand it because nothing else was spoken in her home. The conflict in the home was unceasing. The father, a man of considerable education, had been a printer, but because of failing eyesight had been reduced to the work of a street cleaner. He projected his grievances against life on his family, becoming increasingly difficult and brutal as time went on. The mother, a violent-tempered, uncontrolled peasant woman, unable to read or write, had borne sixteen children at forty-two. Obviously it was impossible that a keen, sensitive, ambitious girl should submit indefinitely to the crudities and brutalities of a father who placed her on a level with her mother, or should countenance what she considered the degrading life of her mother, who gave her little affection and no understanding.

Knowing that Marjorie was the abandoned illegitimate child of an irresponsible mother who had three other illegitimate children, one wonders how she could have had an I.Q. of 112. The unknown father must surely deserve credit for this.

Marjorie was raised in a foster home in which there was constant dissension. The father was fond of her, but the mother tried for years to get rid of her, caring only about another foster child, a boy. They finally separated, and Marjorie found herself at fifteen compelled to live with a half sister. Marjorie, with the religious fervor so often characteristic of adolescence, had decided to become a missionary. The shameless immorality of her sister so revolted her that she sought aid in finding a decent place in which to live. Under the circumstances, her action was entirely intelligent.

Esther had an I.Q. of 111. At a little less than fifteen, with the sensitiveness of adolescence, she began to feel the urge to take care of herself, to be no longer a financial burden to her family. A letter to an out-of-town institution, seeking admission there, resulted in the contact of the organization with her. In this case the maladjustment did not seem to

be particularly serious. Esther is probably a fair type of restless, questing adolescence, unable to realize its dreams and unwilling to accept actualities.

Clara, at fifteen, had an I.Q. of 114. The home with which she was most familiar was a disreputable tent hanging precariously on a hillside overlooking a gully which served as a dumping ground. Not an inappropriate place for her father, all things considered. He was a totally inadequate person, who rationalized his failure to make a living for himself and his children by this philosophy of life: "I would rather starve to death in the gutter than have my friends see me sweeping the streets."

Not an inappropriate place, either, for Clara's sister, a little older than Clara. The mother, fortunately for her, was dead. Clara was taken from the tent on the side of the hill and a home was found for her with understanding people. But the family taint of instability and inadequacy manifested itself in her in such a poor personality that she was unable to adjust herself satisfactorily. It is somewhat difficult in her case to know whether to blame a falling barometer for the rain or the rain for the falling barometer. Was it the casual rearing or the questionable inheritance — or both — that resulted in her maladjustment?

Edna, with an I.Q. of 110, at fifteen and a half lived in a veritable shack. The father, a drunken, miserable brute, literally drove her out of the house, but not before she had become involved in sex delinquency with an elderly reprobate of an uncle.

May, fourteen, falls into the classification of "very superior intelligence" with her I.Q. of 121. An irresponsible mother, divorced from May's own father and equally disgruntled with her second choice, ran away and left May with her stepfather. This stepfather was approaching the final stage of paresis when the case came to the attention of the Women's Protective Association. May's excellent intelligence was too heavily handicapped by youth and inexperience to be able to deal with such a problem alone.

Elsie had an I.Q. of 112. She could not get along with her stepmother in a nearby city, so came to Cleveland to live with an aunt. Shortly afterward the aunt was killed in an

automobile accident, and Elsie went to work in a school home. That she did not find there the satisfaction she craved is evidenced by the fact that she ran away in a short time and has not been heard of since.

Incorrigibility, like maladjustment, is a pretty broad term. According to our records, it may mean anything from impertinence to parents inflated with a sense of their own importance in the cosmic scheme to grave sex delinquency.

Dorothy, at fourteen, had an I.Q. of 115. Her mother complained that she was extremely quarrelsome at home, an accomplished liar, and generally unmanageable. Study revealed that she was laboring under the stress of an extreme emotional conflict which had its genesis in the situation brought about by the divorce of her parents and their subsequent marriages. The situation was complicated by the fact that Dorothy was compelled to live with her mother when she was passionately devoted to her father. Intractable conduct was not an unnatural sequel to such a complicated situation.

Etta, with an I.Q. of 111, was a strong, handsome, undisciplined girl who looked much older than her fifteen years. Her foreign parents, anxious for the money she might be bringing home, wanted her to go to work, entirely blind to the fact that she needed interests to occupy her eager mind and that her ambition to continue in school should be encouraged. Housework, with a little crocheting thrown in for excitement, failed somehow to absorb her energy and to give her sufficient outlet for her ambitions, so she stayed out late at night, chasing the thrills so essential to the happiness of an adolescent.

At two months past fifteen, Syra, from her height of six feet, found herself looking over the heads of her schoolmates by many inches. She was more than able to hold her own with them in school, with her I.Q. of 114, but, anomalous as it may seem, her six feet gave her an uncomfortable feeling of inferiority. It set her apart from her schoolmates, leaving her to find compensation as best she could through omnivorous reading. From her point of view, her mother was unreasonable when she tried to get her to leave the enthralling dream world enclosed in the covers of a book for the

prosy business of washing dishes. Then, too, could a mother expect a great, tall girl like Syra to be tied to her apron strings like a little girl? Of course Syra was irritable, impertinent, and incorrigible at home. Getting back to basal causes, in Syra's case the endocrines are probably the guilty larks!

Belle had an I.Q. of 116. At eleven she thought she could choose her own companions and began to spend a good deal of time at the home of a widow of questionable repute. Her real reason for going there was the fact that she got the attention and opportunity to "show off" that she craved, but did not get at home. Her trouble was straightened out without much difficulty.

The city afforded little opportunity for wholesome recreation for Sophie, nineteen and with an I. Q. of 113. Her association with bad companions brought her to the attention of the organization.

Esther, too, showed poor judgment in choosing her friends, and it was because of this that we came to know her. It was found that Esther had had a very casual rearing by an irresponsible sort of mother. At fourteen she was married; at seventeen, divorced and trying to rid herself of the responsibility involved in raising her child of two. While Esther had an I.Q. of 110, she seemed wholly irresponsible and unstable, unwilling and unable to face life squarely and frankly.

Anna's incorrigibility included lying, stealing from her parents, staying out late at night, and general unmanageableness. At seventeen she weighed 240 pounds, and even a very pretty face and superior intelligence (I.Q. 113) failed to compensate for the psychic distress this physical handicap caused her. She was diagnosed as hyperpituitary. The situation was complicated by the fact that the mother was suffering from a similar endocrine disturbance, and there was some suggestion that the father might be also, although no such diagnosis was ever made. Furthermore, there was the inevitable clash between the American child and foreign parents. Surely there can be found in these factors sufficient cause for the behavior problems Anna presented.

In Katherine's case incorrigibility includes immorality, drinking, and quarrelsomeness at home. Rather appalling

charges to bring against a fourteen-year-old, whose I.Q. of 113 did not seem to prevent her from getting into grave difficulties. Katherine was found to have, quite firmly fixed, the "adopted-child fantasy". She was in open rebellion against anything that savored of authority exerted by a family which she did not believe had any real jurisdiction over her. She proceeded to demonstrate that she was her own boss by getting into behavior difficulties.

Dorothy did nothing more serious than use poor judgment in choosing questionable friends. At thirteen, even with an I.Q. of 113, if the home and community do not furnish recreational opportunities, this is perhaps not to be wondered at. After all, thirteen is pretty young to attempt to make all its own decisions.

Alfreda was ten months past thirteen. Her I.Q. of 114 did not deter her from lying, playing truant, and being immoral and generally incorrigible. She was the product of a broken home traceable to unstable parents, physical overdevelopment, and mental precocity which found no outlet in her home.

Sadie resented her young, domineering stepmother. Furthermore, at seventeen it is a real tragedy not to "make" the club in high school upon which one has set one's heart. Under such conditions, willfulness, quarrelsomeness, and general incorrigibility are not unnatural results, even with a girl with an I.Q. of 110.

Of all the cases discussed in the group, Mary Ann is the most interesting and altogether the most baffling. At thirteen years and five months of age, she had an I.Q. of 110. She was extremely difficult at home, stayed out at night, played truant from school, and was suspected of being immoral. Intensive investigation and study, as well as treatment, have been carried out over a period of more than three years in her case.

Mary Ann's family give practically a clinical picture of a degenerating American family. Alcoholism, resorted to because of a feeling of inadequacy, attempts at suicide, inadequacy in social and industrial life, show themselves with increasing frequency in the history of this family, which numbers Benjamin Franklin among its forebears. If the term "constitutional psychopathic inferior" ever has any justi-

fication, it is in the case of this girl. So far she has been entirely unable, in spite of more than average intelligence, to face life at all adequately. Her last attempt at escape, more futile and more tragic than any of the previous ones, was her marriage to a callow youth, unstable, irresponsible, and probably defective. Within two weeks she found that she had again blundered in trying to solve her problems and was in court seeking a divorce. At the command of the juvenile court, she is getting another chance to see whether she can make a go of things. If not, she is to be sent to an institution.

The six cases discussed under the problem designated as "sex" are so classified because in these six cases sex was the original difficulty for which the girl was referred. It will be readily seen from the cases already discussed that sex delinquency was by no means confined to these six cases. What part the sex urge, as such, plays in the fusion of urges, ideals, and aspirations of adolescent girls becomes increasingly problematical to one dealing with them day after day—despite Freud and his followers.

The case of Mary, eleven years old and with an I.Q. of 125, can be disposed of without much discussion. She was referred because of an incestuous relationship with her stepfather in which she was not a free agent.

Marion, at twenty-one, gave a record of many arrests for prostitution. She came to the attention of the organization because of a charge of miscegenation. Marion attributed her career in sex delinquency to bad companions, jazz, and attendance at colored cabarets when the white ones had failed to afford further thrills. Her I.Q. of 113 had apparently been of little use to her; certainly she had failed to "conduct her affairs with a reasonable degree of prudence".

Betty looked more like a woman of twenty than a girl of fifteen. An invalid mother and a gentle, inadequate sort of father, incapable of dealing with a willful, undisciplined adolescent girl, failed to afford the protection and understanding that Betty required. Her case suggests the possibility of a definite overdevelopment of the sex urge.

In Helen's case we have the old, time-worn, melodramatic theme of the girl betrayed by a man who she did not know

was married and whom she thought she loved. At eighteen she was living and working in the city without the stabilizing influence and protection of a family. She was lonely and impulsive. Her I.Q. of 111 did not save her from falling into grave difficulties, but it did help her in her final adjustment. She assumed the responsibility of rearing her child with excellent grace.

Pauline came to the United States from Germany. She had in Cleveland only a brother, whom she seldom saw. At twenty-one she saw no harm in living with the man she expected to marry and whom she did marry eventually. She found it somewhat surprising that the neighbors thought such conduct reprehensible.

Two of the forty-seven cases studied were referred to the organization for truancy. As in the case of sex delinquency, it is immediately apparent from the cases already given that truancy was not uncommon in this group of girls of superior intelligence, that it is by no means confined to the two cases cited here. They do, however, present some particularly interesting features.

Wilhemina, at sixteen, was in the eleventh grade and at the head of her class. Her very superior intelligence (I.Q. 122) made it possible for her to make progress in spite of many days of absence when she was playing truant. She spent this time at movies or reading in the library. She did not play truant because she disliked school; on the contrary, she loved it.

Wilhemina lived with her father and three sisters; the mother was dead. The father, who had had considerable prestige in his own social group in Germany, was not altogether happy in America. He got no satisfaction from his work—that of a mechanic. In Germany he had been secretary to a general and a man of parts.

The girls were not congenial, and there seemed to be little of that family feeling that makes a home of a house. No doubt these conditions were factors in Wilhemina's maladjustment. However, a more important factor is the possibility of definite psychopathic or even psychotic tendencies in her case. While her actions seemed to point in this direction, it was never possible to persuade her to go to a psychiatrist, and no positive

diagnosis could be made. Wilhemina was decidedly uncoöperative and extremely difficult to work with.

Bessie's case is altogether different, although here again emotional conflict cannot be entirely eliminated as a possible factor. Bessie stayed out of school because she quite frankly hated to go. Part of the reason for this attitude is traceable to the fact that she had changed school twelve times. This would put a strain on the interest of almost any child. Then, too, her father, to whom she had been devoted, had died shortly before she came to the attention of the organization. His death had followed closely on the heels of his divorce from her mother. There had been a great deal of emotional stress involved in these circumstances for Bessie. Added to these things there was a glorious opportunity to play truant because Bessie's mother worked, and this left her at home with practically no supervision.

Three of the forty-seven girls studied came to the Women's Protective Association for assistance in getting employment.

Rena was a charming girl with the typical Irish black hair, blue eyes that looked as if they had been put in with a smutty finger because of the long black lashes, and a wild-rose complexion. When she came to the organization, she was seventeen and a half and had an I.Q. of 113.

Rena seemed unable to keep a job for any length of time. Why was this girl, with the advantages of superior intelligence and excellent appearance, floating about industrially?

She had quit school at the end of her sophomore year, having had the usual required academic subjects and a smattering of commercial courses. So far as training for any specific work was concerned, she had none. Compelled to work because of the financial need of her family, she took what she could get. This proved to be factory work. Having to do this type of work added materially to a feeling of inferiority, the genesis of which is unknown. If there is any such entity as an inferiority complex, Rena had it. The thing was a vicious circle. She had to take work that she felt was beneath her and out of which she could get no satisfaction. The feeling of inferiority increased, undermining her confidence in her ability to do any higher type of work, Until her confidence in herself can be built up and until she can get into work more in keeping with her ability and aspirations, there

is little chance that she will adjust herself satisfactorily industrially.

Lillian also had to leave school at sixteen to help her family. Like Rena, she had completed her sophomore year and, oddly enough, she also had an I.Q. of 113. In her case the problem seemed to be simply the lack of any training that would enable her to get work other than housework, which was distasteful to this sensitive girl of excellent intelligence.

Maurine had completed high school. While a student, she had particularly liked art, but the little training she had had not proved of any commercial value. When she tried to find a job, apparently the only thing open to her was housework or work in a factory. To a girl of her intelligence (I.Q. 119), such work became unbearable. A race horse is as much out of place hitched to a farm wagon as plodding old Dobbin would be on the race track. More significant, however, than the intellectual and tempermental unfitness of such girls as those whose cases have just been discussed for work requiring only a minimum of intelligence is the fact that they were absolutely untrained for any sort of work that would have made possible their satisfactory industrial adjustment. Surely the school is culpable to some extent for this failure to recognize more than average ability and to make it available to the community.

Two girls were referred because they were stranded in the city. One of them, Isabel, was just past nineteen, with an I.Q. of 112. Hers had been the most casual of upbringings by irresponsible, unstable, alcoholic parents. She herself was so unstable that she had at one time been committed to a sanitarium. Cleveland proved to be the western terminus of an automobile ride from New York, undertaken at a moment's notice with a woman friend and two men, chance acquaintances. So far as social and industrial intelligence were concerned, in Isabel's case there seemed to be little correlation with her verbal intelligence.

Hazel, at eighteen and a half, thought that the big city would afford her an opportunity to get employment which the little town in which she lived nearby did not. The fact that she had no training of any kind did not deter her, and her superior intelligence (I.Q. 110) made her ambitious to do

something worth while. The city is seldom as kind as the outlanders anticipate, and it ran true to form in Hazel's case.

The psychoanalytic school has advanced some interesting theories as to why some people steal. They may strain one's credulity somewhat, but at least they afford opportunity for interesting speculation. Was a thwarted urge for power or a thwarted sex urge responsible for the stealing of the four girls to be discussed here?

Jean was almost twenty-one when she was brought to the attention of the organization. Her I.Q. of 110 had enabled her to finish high school and complete two years of college training. She had chosen teaching as a career, and came to Cleveland from a nearby town hoping to secure a position in the schools.

Jean evidently went on the theory that as long as she had blank checks, there were funds in the bank, for she wrote checks as readily and nonchalantly when she had no money in the bank as when she had. This sort of thing had been going on over a period of years, and the embezzlement amounted to hundreds of dollars. She had been given a chance time and again without success, but seemed entirely unable to control this impulse. Finally the matter was taken into court, and she was given a reformatory sentence. This was suspended and she was paroled to the organization, with the understanding that she was to repay all of the money she owed. Supervision in her case extended over a period of five years, during which time she repaid all her obligations. At the end of the five years her attitude had undergone considerable change; she had a good job and was working steadily. Apparently her irresponsible and dishonest habits regarding money have been broken. There still remain, however, personality twists which seem to prevent Jean from facing herself and life frankly and squarely.

Jean's heredity shows a decided streak of instability. Her parents had separated when she was a very small child, the mother leaving for parts unknown. The father, a weak, inadequate sort of person, shunted off the responsibility of his child upon two maiden sisters. They themselves were unstable and one of them is at present confined in a hospital for the insane. Jean's heredity was dubious and her rearing was unwholesome.

It seems strange that a woman with an I.Q. of 110, a graduate nurse holding a responsible position in a large hospital, should be caught shoplifting. Although Berta was extremely uncommunicative, enough was learned of her history to suggest some irresponsibility and instability in her family. At least her mother and father had separated when Berta was a small child, and she had been raised in a house with a stepfather for whom she did not care.

On the face of it, Berta's stealing would seem to be of a pathological nature. If this is true, for what was it a compensatory mechanism? The contact of the organization with her was so brief that any attempted answer to this question would be pure speculation.

Frances, at fifteen, got into trouble in school for petty thieving. Other than this she was not a problem in school, for her I.Q. of 111 enabled her to get her school work easily. It is questionable whether Frances could be accused of pathological stealing, since it is much more reasonable in her case to assume that she took the little, frivolous things which mean so much to an adolescent and which she was unable to buy.

Esther was no common shoplifter. Her intelligence (I.Q. 110) enabled her to invent an ingenious scheme whereby she robbed the store in which she worked over a long period without being discovered. It is doubtful if it would ever have been unearthed had it not been necessary for Esther to make use of some accomplices who proved less clever than herself. One may surmise in Esther's case that she derived a certain amount of satisfaction, a feeling of power, from thus outwitting her employers—or one may be prosaic and believe that she really quite simply wanted the things which her meager salary and obligations at home made it impossible for her to obtain in any other way.

Of the three remaining cases, Alice, at eighteen, was working in an isolated ticket office where she was subjected to the insults of strange men. Her I.Q. of 110 indicated that she could do rather a high type of work, but her training was such that she was not prepared for anything that was suitable for her. It was this fact that induced her in the first place to accept the dubious work which she finally had to leave.

Ena had been an excellent student in high school and wanted

passionately to go to college. Her I.Q. of 116 backed up this ambition, but the family finances were entirely inadequate for such a plan.

Cornelia was a college graduate. In the course of her daily work she had come in contact with a girl running an elevator in the building in which she worked. Finding the latter lonesome, she became quite friendly with her, only to discover to her dismay that her friend was peculiar. Cornelia became frightened at the ardency of her friend (which included jealous threats of death) and sought protection from her.

It is apparent that there is little uniformity in the types of problem encountered in the cases of these forty-seven girls of superior intelligence. In fact, their cases give practically a cross section of the problems encountered in dealing with adolescent girls as a whole. It would seem that superior intelligence alone is no guarantee against tripping up in the business of living.

It is interesting to note that in only one case, that of Ena, does there appear to be a single, clean-cut problem, and even there there may be unknown complicating factors. Just as we find in practically each case analyzed a number of different sorts of deviations from socially acceptable behavior, so we can expect to find a multiplicity of causative factors at work. Each case presents the picture of an individual at odds in some manner with the social environment. To what extent are factors within the individual himself responsible? It is impossible, of course, for any one to answer such a question conclusively. We can merely attempt to disentangle the nexus and interpret it more or less arbitrarily.

In such a procedure we can logically begin with heredity, so far as it is known or appears to be significant. In fifteen cases, or practically one-third of the total, there was marked instability on the paternal side and in eleven on the maternal. Three cases disclosed a history of insanity on the paternal side; one on the maternal. Two fathers and four mothers were known to have been immoral. There was a history of known venereal disease in the parents in two cases. One father was a criminal. Three fathers and one mother were alcoholic; one father and one mother were tuberculous; one mother showed symptoms of endocrine disturbance.

The outstanding fact here is the large percentage of cases that show marked emotional instability in the parents. This is highly significant in the light of the fact that the deviations from normal behavior shown in the cases studied indicate marked instability in the girls.

Health and personal appearance are unquestionably vital factors in social adjustment. In a number of studies of individuals with superior intelligence, it has been quite generally found that there is a positive correlation between health, good appearance, and high-grade intelligence. The present study would seem to confirm these findings. In only seven of the forty-seven cases was there any suggestion of poor health. Six had goiters; six had or had had gonorrhea; one was in an advanced stage of tuberculosis; one had chronic appendicitis; there was one case of rupture; one was hyperpituitary; two showed signs of malnourishment; and three needed dental care. There was enough overlapping of these disorders so that the total number handicapped in health was only seven. There were no cases of defects in hearing and only three cases of eye defects, corrected in each instance by glasses. Thirty-two of the girls were judged to have good or excellent personal appearance; twelve were considered average; and only three were decidedly unfortunate in this particular. Apparently health and appearance were not important factors in the maladjustment of this group of girls.

So far as mental health can be determined in these cases, fifteen, or about a third, were thought to show some emotional instability, and thirteen marked instability; five were suspected of being psychopathic, and two were definitely diagnosed as such. This leaves only twelve, or barely more than a fourth of the entire number, who were considered perfectly normal. It is altogether possible that if all the facts were known, even this small number would be reduced. It would appear that just here we have the most significant fact brought out in this study. Emotional instability and psychopathic trends, whatever their genesis, put a tremendous handicap on even those fortunate individuals who possess superior intelligence. Is it not reasonable to believe that had some agency of the community detected these trends in the early childhood of the girls studied and made use of the hereditary potentiality—the superior intelligence—some, if not all, of the

gross deviations from socially desirable behavior could have been forestalled?

What part, if any, does nationality play in the problems of these girls? Doubtless conflicts in the home, due to the clashing between parents with the standards, ideals, and customs of old Europe and children with what they conceive to be those of young America, are one of the most fruitful sources of maladjustment. Cleveland has a very large foreign population and on the average about two-thirds of the girls handled by the Women's Protective Association are of foreign-born parentage. In 1926 one-fifth of the total number were themselves foreign born. Of the forty-seven cases studied in the present investigation, on the other hand, only seventeen, or a little over one-third, were of foreign-born parentage, and only two were themselves foreign born. The distribution was as follows: in six cases the parents were Hungarian; in five, German; in three, Italian; in two, Polish; and in one, Serbian. One of the foreign-born girls was born in Hungary, the other in Serbia.

It is not altogether easy to explain the fact that while on the average two-thirds of the total number of girls handled by the organization are of foreign parentage, the figures are practically reversed in the case of the group with superior intelligence. If one were afflicted with the Nordic complex, it would doubtless be simple enough. It is much more probable, however, that the fault lies with the measuring rod used rather than in any racial endowment or lack of it. Being raised in a family where a language other than English is spoken constitutes a very real handicap for an individual faced with the practically purely verbalistic Stanford-Binet test. In those seventeen cases where the I.Q. was in the superior group despite this handicap, it is probable that it would have been even higher had a test been available that would have eliminated this handicap. It is also highly probable that the 1 per cent of the 3,164 cases tested that fall in the superior group is far short of the actual number that should be there.

Having discussed what may be termed possible individual causative factors in the maladjustment of our group of girls of superior intelligence, we have next for consideration those that lie outside the individual.

What was the home situation in these cases? Both parents of one girl were dead. In eleven cases the mother was dead and in six the father. In ten cases the parents were divorced. Twelve of the girls had stepmothers and nine had stepfathers. Four were living with foster parents; two with strangers; and three with relatives. Of the forty-seven, only fourteen were living in unbroken homes. The sociologist immediately siezes upon this—but the psychologist is not satisfied with this social fact. In those ten cases where the family was broken through divorce of the parents, it seems reasonable to assume that there was some degree of instability and irresponsibility. In most of these cases, indeed, it is a known fact. At least a tentative hypothesis may be made that a possible inherent tendency toward instability was more significant in determining the girl's inadequacy in adapting herself to her environment than the mere fact that the home was broken.

What has the school done for these girls of superior intelligence, and to what extent have the girls adjusted themselves satisfactorily to the school situation? A tabulation of school grades completed shows that twelve of the forty-seven completed high school; one completed one year of college, and one, two years of college; one had an A.B. degree. Five of the forty-seven had had training in commercial schools, and one was a graduate nurse. It was interesting to find that none of the forty-seven had skipped more than one year of school, and only seven had skipped one. One girl repeated one year, and five had repeated some subjects in high school.

Twenty-eight were not problems of any kind in school. This leaves nineteen who were school problems. It would be very easy to indict the school system on the basis of these figures, and it doubtless did fail somewhere along the line. When we face the fact that eight of these girls of superior intelligence played truant, seven were incorrigible in school, and five were failing in their subjects, certainly the school could not have been making the most of its opportunity and of its obligation to the community to make available for its use these potential leaders. It is interesting to speculate upon what would have happened if the com-

munity had had visiting teachers available to handle such problems as these girls presented. In all justice, of course, it must be borne in mind that these girls came to school with an heredity and with well-established habit patterns for which the school was in no wise responsible.

The church was apparently almost an entirely negligible factor in these cases. Thirty-three of the girls were Protestants; twelve, Catholics; and two, Jewish. In only one case did church or creed seem to be of any special significance in the life of the girl. In this case the girl was desirous of becoming a missionary, and it was largely because of her religious trend that she revolted against the conditions under which she was living and so came to the attention of the organization.

Occupations cannot be disregarded in a consideration of the vital factors in the social problem. Twenty-six of the girls studied were schoolgirls at the time of reference; eight were engaged in clerical or stenographic work; two were doing housework; two were telephone operators; one was a trained nurse; two were teachers; one worked in a factory; one was doing a little unsuccessful commercial art; one was a saleswoman in a store; two were professional prostitutes; and one had no occupation.

It is significant that of the twenty-one cases not schoolgirls, only three were engaged in the professional work for which, so far as verbal intelligence is concerned, all of them were qualified. It is also notable that the girl with the highest rating was brought to the organization after running away from a housework job! From the standpoint of occupations, the outstanding fact seems to be that lack of training for a specific job constitutes a handicap that it is difficult for even individuals with superior intelligence to surmount.

One or more of the social institutions had failed in practically every one of the cases studied in this investigation. It was for this reason that it became necessary for the Women's Protective Association to undertake, through manipulation of the environment and through an attempt to help the individual gain insight into her own personality and her problems, to bring about an adjustment that would make it

possible for the girl, as an individual, to find life a more satisfactory thing and, as a member of the community, to make a contribution in keeping with her potentialities.

The length of the service given the girls by this organization ranged from one month to more than five years, the average time being a little more than thirteen months. The types of service included intensive investigation; coöperation with other social institutions and agencies; medical, surgical, and dental care; shelter, observation, and training at Sterling House, a temporary home maintained by the organization; psychological study; psychiatric study and psychotherapy; the opportunity of living at Prospect Club, the association's boarding club for girls; the securing of employment; and plans for recreation, including summer camps. Over and above all, however, through personal contacts with the various workers in the organization, an attempt was made to bring about those intangible changes in the attitudes and ideals of both girls and their families which are so vital in any effective program of social case-work.

An attempt at an evaluation of the results achieved by the Women's Protective Association in working with the forty-seven girls studied in this investigation encounters certain difficulties. Where a social organization is giving relief or doing work of this nature, it is relatively simple to subject the results to some sort of statistical treatment. But in the case of the subjects of this study, the situation is altogether different. It is, of course, possible to state definitely that immediate crises, such as being out of employment, being stranded, running away, playing truant, needing physical care, and the like, were met at once. It is not so simple to estimate final results, which are, in the last analysis, much more vital. Has the girl gained insight into her own personality and her problem? To what extent have efforts to change undesirable attitudes and ideals been successful? What reëducation in the matter of habits has been accomplished? In short, to what extent has it been possible to eliminate or ameliorate those factors in the individual and her environment which have been instrumental in bringing about her maladjustment?

It would be delightful to be able to bring this investigation

to a close with the ending of the good old fairy tale—"and so they lived happily ever afterward". Candor, however, would not permit this. In the first place, it must be remembered that we have to deal here with a multiplicity of causes, some rooted in the individual and others in the community, so inextricably interwoven by the time adolescence is reached that disentangling them is extremely difficult. Consequently, it is not to be wondered at that attempts at aiding the girl in readjustment are often baffled.

Again, some of the girls have left the community, and we do not know how satisfactorily they are adjusting themselves. Over a fourth of the total number are still active cases, and it is impossible to be sure of the outcome so far as they are concerned. A number of the girls have married, but it is as yet problematical how well they will adjust in this relationship, having failed in others. It seems very significant that, so far as is known at present, not one of these forty-seven girls, whose hereditary potentiality, so far as verbal intelligence is concerned, was much above the average, has apparently made use of that potentiality. This would suggest certain tentative conclusions.

Superior intelligence, *per se,* does not seem to guarantee that the individual possessing it is immune from involvement in perplexing problems and distressing situations, or that, once having become so involved, she can extricate herself much better than her less well-endowed fellow. In point of fact, it would seem that superior intelligence, when handicapped by emotional instability, overlaid by undesirable habits, or circumscribed by circumstances such as poverty, undesirable home conditions, and lack of training, complicates the problem instead of simplifying it. Whereas it is easy to find in the cases of the organization many girls who have made excellent adjustments even when ostensibly handicapped by dull or border-line intelligence, this group of girls of superior intelligence seems conspicuous by its failure. Does their very intelligence give them ambitions which, being thwarted, produce undesirable results in behavior? Does it make them unwilling to accept complacently conditions which their duller fellows find tolerable? Does it make them resentful of an obviously unfair social order and thereby

produce socially undesirable revolt against all constituted authority, however expressed? Or does the onus lie with the community, which has failed to find them early enough to give them every opportunity to develop to the maximum? These are all questions that are open to speculation in an attempt to explain the facts presented by the maladjustment.

We can do nothing more than speculate as to what the outcome would have been in these cases had the potentiality of these girls been recognized when they were small children, had efforts been made in the direction of mental hygiene which might have prevented the development of undesirable emotional trends and conflicts. We have no way of determining to what extent the questionable heredity in many of the cases would have baffled all efforts, however early they might have been undertaken. We do know that casual rearing and a lack of recognition and utilization of potentialities added to the difficulties encountered by these girls in making use of their great asset of superior intelligence. There can, of course, be no question that society has suffered a real loss through its failure to do its part in affording them every opportunity to make their maximum contribution.

WHAT THE ADOLESCENT GIRL NEEDS IN HER HOME *

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THE concepts by which an attempt is made to explain and manage human behavior are of such recent development and seem to differ so widely from the beliefs of previous centuries that it seems advisable frequently to scrutinize their reliability and value. This is perhaps more necessary for those who have to do with the adolescent than in the case of any other phase of human development. Consequently, before the needs of the adolescent girl in the home can be discussed intelligently, it seems advisable to consider certain fundamental aspects of the adolescent period:

1. What is meant by the term "adolescent period"?
2. How does adolescence differ from any other stage of the process of growing up?
3. Are the problems that arise at this period peculiar to adolescence in general or to adolescence in a particular form of society; and if the latter be the case, what is there in our form of society that contributes to their development?
4. What is the outstanding symptomatic behavior of the adolescent period, and what are the factors either within the individual or in the environment—the school, the group, and particularly the home—that seem to cause this behavior?

None of these questions are as simple as they seem.

The process of growing up may be divided roughly into four stages—infancy, late childhood, adolescence, and adulthood, each stage being of variable length and shading imperceptibly into its successor. The adolescent period begins about the time of the onset of puberty and lasts for a varying period,

* Read before the Home Economics Division of the American Vocational Association, Philadelphia, December 15, 1928.

depending upon race and degree of civilization. Among primitive peoples it is relatively short, consisting, for the boy, of his initiation into the carefully guarded tribal and religious secrets, and for the girl in a period of seclusion until the awe-inspiring menstrual function has been fully established. After these ceremonies the child is accepted by the whole tribe as an independent adult, being accorded the full responsibilities and privileges of adults, and the system of taboos separates him completely from the always loosely knit family group. The parents show no hesitation in permitting the initiation ceremonies, because such are recognized as the unvarying custom of the tribe, and the age at which the ceremonies occur is the same for all, regardless of the social or other status of the individual.

As the cultural standards become higher, the training required to fit certain individuals for their place in society requires a prolongation of the adolescent period for them, so that all persons do not assume adult status at the same age. In the Greco-Roman civilizations the adolescent period often lasted five years, while to-day in America its length is very variable—those who enter the professions may emerge from it only at the age of twenty-five or thirty years. This prolongation of adolescence far past the time when physical maturity is attained, and above all the variation in the age at which individuals are permitted the responsibilties and privileges of adulthood, produces a situation of peculiar difficulty for the adolescent girl of to-day. A prolonged adolescence means that her dependence on her family during a long academic career may restrict her from enjoying the freedom permitted to her neighbors who are wage earners already, and yet she is expected to be able to control her fundamental urges, such as that of the newly reactivated sex impulse—a control that may be impossible for many so-called mature adults.

Each one of the stages of growing up offers difficulties of adjustment, but there are particular peculiarities about adolescence that make its difficulties very real. It is the threshold of adulthood, and the next step means severing many of the family ties. It means the change from the status of a dependent or semidependent to one of dependence on

oneself. It means relinquishing a position in which a girl is accepted more by right of birth than because of the attractiveness of her personality or her ability to impress her intrinsic worth on her associates, and entering an atmosphere where she must make her own place through her own efforts. No wonder the adolescent girl, as Longfellow says, stands

"With reluctant feet
Where the brook and river meet."

It is a step to be faced with many misgivings, and the ease and certainty with which she can take it is the measure of her degree of adulthood.

After the next two questions have been discussed, it will be seen clearly that the real problem for the adolescent girl lies in the degree of maturity she brings to puberty, but before such a statement can be advanced with assurance, it is necessary to consider the third question: *Are the problems that arise during the adolescent period peculiar to adolescence in general or to adolescence in a particular social organization, and if the latter is the case, what is there in our form of society that contributes to their development?*

It has been customary to regard adolescence as a period of stress and strain—one peculiarly liable to problems of behavior and adjustment—and it is almost as customary to place the blame for this instability on the physiological changes associated with puberty. Were this the case, the adolescent—and particularly the adolescent girl, whose puberty begins in a more dramatic fashion than the boy's—would show signs of this instability regardless of race, color, or degree of civilization. Mead[1] lived among a group of adolescent girls in Samoa and found little if any difference between the behavior and personality of those who had attained puberty and those who had not. Although it is true that the sex impulse, very active in infancy, apparently latent in late childhood, becomes more active again at puberty, this urge is normal, and Mead's study, as well as those of Malinowski[2] and others among primitive races, indicates that where

1 *Coming of Age in Samoa*, by Margaret Mead. New York: William Morrow and Company, 1928.

2 "Prenuptial Intercourse Between the Sexes in the Trobriand Islands," by Bronislaw Malinowski. *Psychoanalytic Review*, Vol. 14, pp. 20–36, January, 1927.

sexuality is accepted in a matter-of-fact manner, the physiological changes of puberty do not seem responsible for the instability of the adolescent, for such instability is not found in primitive girls. (One wonders if the emphasis laid on the relation between sexual development and adolescent difficulties is not partly an attempt on our part as parents and teachers to shift the responsibility for the problems observed in our children at this period from our own shoulders to theirs, in order to excuse our own shortcomings, and partly the outgrowth of our own feelings about sex—*i.e.*, that it is too fearful a thing into which to initiate any one without upsetting his or her emotional life completely.)

If the instability of adolescence does not result from physiological processes and is found in America, but not in Samoa, it must be associated with the social organization in which the child lives, and when one compares primitive society with that found in America, it is evident that the latter places a great many difficulties in the way of the adolescent urge to grow up—an urge that exists in every human being from the moment of birth and is always present in some degree, although the amount that is manifest at adolescence is dependent on the degree to which the pre-adolescent child has been permitted to develop his desire for independence. The social organization meets this desire in conflicting ways. The school system[1] tends to continue the child's dependence by making school attendance compulsory until the seventh grade, or the age of sixteen, is reached, regardless of whether a particular child has the capacity to profit by education, whether the child feels it a real duty to become a wage earner, or whether the home is intellectually ambitious. It does offer to those children who are ambitious intellectually a certain degree of independence under the departmental régime, but the amount of real responsibility given to the individual child is slight. Some of the older religious organizations accord full church privileges at puberty, others withhold them till much later. There are few parents who do not fear to permit their adolescent daughters even the measure of responsibility and privileges that the child is fully capable of accepting. This

[1] In Pennsylvania.

is understandable from the parents' point of view because the years between the child's birth and her adolescence cover so brief a period in the adult's life that it is very hard to realize that the baby of yesterday is nearly grown up to-day. Some parents find it difficult to accept their children as adults even after they have attained their majority. Indeed, some desire to continue to circumscribe with their loving care the son or daughter who is approaching middle age. Often the parents, and other adults as well, fear the girl's growing interest in boys and endeavor to repress it, although it is a perfectly normal response to her sex urges, and one that if it were not displayed during adolescence, might indicate that her psycho-sexual development was retarded and that she was in danger of encountering serious difficulties of adjustment in adult life. Even though the parents do not frown actively on her attraction to boys, both they and society condemn any adolescent attempt to obtain sexual satisfaction either through marriage or semi-promiscuous experimentation, expecting the girl to exercise greater self-control than many adults can.

These are only a few of the difficulties that the adolescent must face. On the one hand, she is impelled by her inner urge to desire to grow up; she is stimulated by the workaday world (if she leaves school) and by the semi-responsibilities of high school (if she does not) to take on a greater measure of responsibilities and privileges; she is desirous of having the same measure of freedom as her companions. On the other hand, she is somewhat loath to relinquish the easy satisfactions of babyhood and is urged to cling to them by the restrictions imposed by the school and the over-anxious, protective love of her parents. This places her in a situation of conflict. She desires to continue to be pleasing to her parents, yet desires even more earnestly to be accepted by her associates (as she must be if she expects to make an adult adjustment); and as the values and standards of these companions must differ from those of her parents in a country where side by side may live a Republican and a Democrat, an atheist and an evangelical, a family whose sole aim in life is the accumulation of material wealth and a family whose goal is an intellectual one, her difficulties become in-

creasingly great. It is no wonder that adolescence presents problems; the wonder is that the period passes so frequently without serious difficulties.

It seems clear that the problems of adolescence are not inherent in the physical changes of puberty, but result from the attitudes and divergencies of opinion in the social organization in which the adolescent lives. However, this social organization exists and maintains its existence because it has certain definite values, and the question is not how we can alter society to fit the adolescent, but how we can prepare the child to adjust herself to the social organization of to-day.

When one studies a number of adolescent girls, one is struck by the frequency with which the child expresses verbally and through behavior a feeling of being inferior—of being less capable or worth while than her companions. Of course a feeling of inadequacy must be common at adolescence, when one considers the adolescent's uncertainty about growing up and the social hindrances already mentioned. Probably the need the adolescent feels to be first in something, to shine in athletics, to wear more modish clothes, to have more signs of material prosperity than her companions, to surpass them in school work, results from this feeling of inadequacy. The following list of needs of an adolescent girl, composed in December, 1928, by a girl just entering puberty, is of interest in this connection.

WHAT THE ADOLESCENT GIRL REQUIRES

1. She should not have a smaller brother or sister going or doing everything she does.
2. She should be allowed out at night.
3. She should have a room to herself.
4. She should have plenty of pretty clothes.
5. She should take music lessons.
6. She should have a large allowance.
7. She should have a desk of her own.
8. She should have plenty of books of her own.
9. She should have free time of her own.
10. She should not use cosmetics.
11. She should have a clean character.
12. She should not boss others.
13. She should have a useful hobby.
14. She should not use her hobby for gambling.
15. She should be a good sport.
16. She should be thrifty.

17. She should try to enter college.
18. She should not smoke.
19. She should not go to cabarets or wild places.
20. She should not wear long clothes.
21. She should not see pictures or plays that are not fit for her.
22. She should not play wild games.
23. She should keep herself clean and fit.
24. She should not drink tea or coffee.
25. She should not partake in cabaret dances.
26. She should not hitch-hike.
27. She should not neglect her school work for other things.
28. She should be obedient to her parents and older people.
29. She should belong to a club.
30. She should have an ambition.
31. She should bank once a week, putting in considerable sums.
32. She should have a regular bedtime.

This child's feeling of inadequacy expresses itself in her wish for material possessions for herself and in her desire to conform to the group rather than the home (because many of the activities she prohibits for herself, such as smoking, cabarets, and so forth, are carried on by her parents, but not by the other families in that particular locality). Of course in this case there are other reasons for her feeling of inadequacy—her jealousy of her younger sister, for example—which are of equal, if not greater, importance than her difficulties of social adjustment, but some of the cases studied at the Philadelphia Child Guidance Clinic show that the social organization does increase the feeling of inadequacy in certain individuals.

Case 1. Clinic No. 803. I. Y., a fourteen-year-old white girl, was referred because she was nervous and restless in school, impudent and unmanageable with certain teachers, and because she was having temper tantrums in which she would scream, pull her hair, stamp, and tear at her clothing. With teachers who showed her considerable sympathy, her behavior was not remarkable, but if her work was criticized, she felt that the critical teacher had a grudge against her and used every opportunity to taunt him. She fidgeted, bit her nails, and was constantly doing something to attract attention to herself. She circulated scandalous stories about boys and other girls. She had been no problem before she entered high school, but there she failed twice in succession, and it was probable that she would fail this term also.

A study of the situations in which she had her outbursts revealed that the misbehavior occurred when the school work was particularly difficult. Her mother had trained the girl to desire to finish high school and enter the nursing profession, and neither of them realized that she lacked

the ability to carry out this program (although on examination her I.Q. was found to be 73 and her school placement far in advance of her mental age), nor did they understand that there was any connection between the outbursts and her difficulties with school work. Her behavior was unquestionably the result of her despair at not being able to keep pace with her more intelligent associates and comply with her mother's ambition, and she was forced to lay the blame on the hostility of her teachers because this was less unsatisfying to her than to admit her own incapacity.

Although in this case the urge to continue in school was not due entirely to the demands of the educational system, yet many similar cases could be quoted in which the school alone has made as unfair demands on the child. Obvious as such problems are, they exist to-day in the schools with disheartening frequency, but the treatment is so obvious that they do not present as alarming situations as when the feeling of inadequacy is based on deeper-seated and more subtle causes —causes that lie in the home situation of the pre-adolescent and adolescent years, and that do not differ materially from those underlying the problems that occur at any other point in the process of growing up. The unacceptable behavior is symptomatic of the degree to which the home has prepared the child for facing the difficulties of social adjustment, and it assumes more alarming proportions at adolescence because the child is extending her activities beyond the home. A few of these problems and the situations out of which they arise will make this point clearer.

Case 2. Clinic No. 995. J. B., a white girl, aged sixteen years, was referred to the clinic by her mother because she stayed out late at night, had run away, played truant from school, was associating with undesirable boys and men, stole, displayed an ungovernable temper, and refused to discuss any of her pursuits with her mother. She was the middle child in a family of three girls. The mother never spent much time with her children, but lavished what attention and affection she gave them on the youngest, who responded better to her than the others. The youngest girl was too young to be companionable with her sister, while the eldest had openly expressed an aversion for the patient since her birth. The patient's father was very fond of her, but he died when she was six years old, and since that time she had felt that no one in the home really wanted her. Unhappy there, she turned to outside interests for satisfaction, and met an older girl who was much more sophisticated than she was. The patient was physically well developed, and older boys and men to whom she was introduced by her friend found

her attractive. She escaped from an irritating home atmosphere to those who seemed to like her and was willing to go to almost any length to retain their affection—*i.e.*, to feel that she was wanted by somebody. Feeling that her mother was not fond of her, she would not discuss her pursuits with her, and her uncommunicativeness confirmed the rumors to which her behavior had given rise and caused her mother intense alarm, which alarm was felt by the patient as further evidence of the mother's dislike.

In another case in which the situation was somewhat analagous the girl desired to get away from an uncongenial home and, meeting some sailors, asked them to take her with them. They promised, provided she would submit to sexual relations. Her desire to escape was so great, and her need to retain the affection of any one who seemed really interested in her for her own sake was so urgent, that she consented, although she experienced no pleasure from the intercourse.

Case 3. Clinic No. 842. M. G., a fifteen-year-old girl, was referred to the clinic by the institution in which she lived because of violent temper tantrums, sulkiness, jealousy of other girls, and very disagreeable behavior. This behavior occurred only when she was associated with the house mother of the division in which she lived. At school and in her other activities, she presented no problem. Her mother had died when the patient was very young, and after living several years with a woman who she thought was her mother, she was placed in the institution because of her foster mother's illness. Several years later she was told the true story of her life, and about the same time she was placed under the care of the house mother, who was a lonely individual and because of this loneliness tended to encourage crushes. The patient said little about what she had learned, but soon formed an extreme attachment to the house mother. Another girl in the same group was also very fond of the house mother, and violent jealousy between the two girls developed. The patient interpreted the house mother's attempt to be impartial to both girls as a dislike of herself, tried to attract the woman's attention, and had violent temper attacks followed by the most abject penitence. All this time she cherished a violent hatred of her own mother for putting her away. When she was removed from the division in which she lived, and when, through the development of a friendly relationship with a psychiatrist, it was possible to get her to discuss her feeling about her mother and to understand some of the reasons why her mother had to give her up, her behavior became quite acceptable.

These three cases illustrate the need that every child feels for affection and to be certain that he has a welcome place in the family circle.

Case 4. Clinic No. 113. L. B., a fourteen-year-old white girl, was referred because she resisted all authority and was beyond the control of her parents. In order to get her own way at home, she would strike at or curse any member of the household, and she was as antagonistic to any one outside her home who tried to interfere with her. Her father was a very henpecked man, dominated by his wife and extremely indulgent to the patient. Although the mother dominated the household, she was completely subservient to the patient's whims, and would go to any length to shield the girl from the consequences of her behavior. The attitude of both parents was not of recent date, but had existed from the time of her birth. As she had never learned that there was such a thing as reality, the patient was unable to conceive of any authority that was more powerful than her own whim of the moment. When her behavior began to alarm her parents, they attempted to restrain it, and the patient reacted in the way she had always found successful—*i.e.*, by demanding her desires with violence. Finding that people outside her family circle were not willing to lavish all their attention on her, she reacted in a similar way to them, for she felt that they were depriving her of her just rights.

A similar situation is seen in the case of a woman now aged eighty, whose behavior has always been disagreeable. She has lived in over a dozen hotels and another dozen sanatoriums and has been asked to leave each one because she was unable to live peaceably with any one. Greatly indulged when a small child, she has never relinquished her infantile feeling of being all-powerful, and because other people would not accede to her least whim, she has felt that the whole world is against her and is seeking to deprive her of her just rights, and so has justified her temper tantrums and other babyish behavior. Neither this woman nor the girl has ever developed emotionally beyond infancy because of the indulgence of their parents during their early childhood, and so both were utterly unfit to face the non-indulgence of the outside world when they came into contact with it. Nor were the parents able to cope with the situation when the results of their indulgence brought the child into conflict with their ideals.

It should not be forgotten that when parents indulge a child, they do so in response to their own emotional needs and consequently cannot alter their attitude merely by being told what they are doing. The attempt to make the child satisfy an unsatisfying parental life often produces difficulties when the child reaches adolescence. This is illustrated by the following case:

Case 5. Clinic No. 1227. F. G., a thirteen-year-old white girl, was referred to the clinic because she was failing in school, although she had superior mental ability. She was moody and disagreeable with her mother, and was associating with companions whom the mother considered undesirable. She was the youngest child of a large family of girls and had been born a few months before her father's death. Her mother, rather poorly educated herself, and as a consequence having to work very hard for her livelihood and feeling very lonely and out of place in the world, centered her whole attention on her family. The slightest illness meant that the children remained away from school for fear that they would die. She sacrificed that they might have a good education; she desired to give them as good a home as possible; but because her circumstances did not permit this, she impressed upon them how necessary it was for them to work and contribute to the upbuilding of the home. She did not want any of them to marry.

The youngest child was the mother's favorite and slept with her, and an elder sister was forced to give up a scholarship in order that the patient might have more advantages. As long as the patient was the baby of the family, things went smoothly, but when she desired to make outside friends, her mother criticized the friends she chose, refused to allow her to bring them to the house, did not want her to have any boy friends, and would not permit her to have the freedom her friends had. Her elder sister collaborated with the mother in restricting the girl's social contacts until the patient rebelled and began to indulge in clandestine meetings with friends of both sexes.

The mother was quite satisfied as long as the girl remained her baby and she could direct her every move, but as soon as the girl showed signs of wanting to grow up—to express her individuality, which had not been completely submerged because her mother had been away from home nearly every day working, and the child could develop some independence during those times—the mother resisted it. Her attitude has led the girl to feel that her mother is not giving her the freedom her associates have because she does not love her. The girl's attitude so far has been rather a healthy one, although she cannot yet understand her mother; but if the mother's attempt to restrict her independence continues, the patient probably will develop more serious behavior difficulties.

Another way in which the family contributes to the difficulties of adolescence is seen in the following case:

Anna was an attractive seventeen-year-old girl, whose parents asked for help because they had become worried over her melancholy attitude. They reported that she had seemed depressed for some time and that she was heard crying every night after she went to bed. Anna was very reticent about her affairs for a long time, but finally, after becoming friendly with one of the clinic workers, disclosed her troubles.

In order to assist in the support of her family, she had left school and gone to work in a factory. She did not like the work, for she was a bright girl and had other ambitions for herself. However, she kept the need of her family in mind and forced herself to continue at the uncongenial occupation. The working conditions proved bad for her

physical health, and she finally became so ill that she realized that she would have to give up work for two or three weeks. This worried her considerably, as she pictured the distress of her family when her weekly wages should be withdrawn for this period. While she was thus worried over financial matters, an opportunity to pick up the sum of $50 at a friend's home presented itself. Anna took the money, pretended to go to work and return at the usual hours, and produced the regular weekly wages out of her stolen funds.

Anna's depression, and the weeping at night that had so worried her parents, were the result of her feelings of guilt about the matter. Although she had satisfied her conscience so far as her duty to her family was concerned, she had added a heavier burden otherwise. She was helped to explain to her parents what had happened, the money that she had appropriated was returned with their aid, she was placed under a physician's care in order to build up her health, and finally a job was secured for her that offered some opportunity for advancement and was more commensurate with her excellent mental abilities.

These cases indicate that the serious problems at adolescence result in part from the way in which the pre-adolescent child has been prepared for adult adjustment and in part from the attitude of the parents during the adolescent period. If the child has been indulged to the point where she has never lost her infantile feeling of omnipotence, she comes to demand from the world what she always has obtained from her parents, and when faced with reality at adolescence, feels, and may continue to feel throughout her life, that she has been cheated—that the world owes her the homage and adoration that were hers in childhood, and because she does not receive this, she feels frustrated and deprived and behaves disagreeably. If the child has felt that she is unwanted, she is forced to seek persons outside the home who will want her. If this need is filled by an older woman who is at the same time satisfying a need of her own with the child's affection, the girl may be prevented from ever gaining any satisfaction from the affection of the opposite sex. If she is able, through her beauty, dress, and so forth, to attract the attention of boys or older men, she may be willing to sacrifice her virtue in order to retain their regard. If she has attained a certain degree of independence, although the home atmosphere is a protective one, she may desire eagerly to grow up, but this desire will bring her into conflict with the protective home atmosphere and her attempts to establish her individuality, being regarded as rebellion, may force her to rebel still more.

If the child feels too responsible for the family, she may adopt antisocial behavior to obtain for the family what she thinks they need. If she has found dependence more satisfying than independence, she may be unable to take her place in society and always remain tied emotionally to her parents' apron strings. Conversely, if the child in her early childhood feels that she is loved and wanted by both parents and that her efforts at independent action are pleasing to them, that the things she can do for herself—partly in imitation of her mother—are of value to her mother and also to her father, that she is welcomed both for what she is and what she can do, she will develop true self-confidence and be able to face the difficult social situation at adolescence without being either too fearful or having to emphasize her importance too much. At the same time, if her parents can gradually withdraw their protection, her passage through adolescence becomes relatively simple. Of course it is useless to tell a parent of the type described in these case histories where their behavior is inadvisable, because their behavior is only an attempt to satisfy their own needs through the child. The real solution of the problem of adolescence lies in the adjustment of the parents to their lives and to each other. If the child must satisfy some need of one or both parents, her personality cannot become integrated sufficiently to face adolescence without difficulty.

Parents must understand not only the real needs of the child, but their own needs, and be able to satisfy them in a more wholesome manner than at the child's expense. This is the ideal plan to prevent the difficulties of adolescence, but what of those cases that are problems already? A similar plan continued over a long period of time will help, but the main treatment must be with the child herself, because her personality has been warped by the time puberty is reached. In a few cases such as those in which the mentality of the child is too low for further school progress, a change in occupation may help, but the cause of the vast majority of the problems is too deep-seated to be helped in such a superficial manner. Parents of children who have adolescent difficulties cannot help their children much, for it is their attitudes that have produced the problem, and they cannot change these

attitudes overnight. It should be remembered that the behavior of the child, obnoxious as it may be, is simply an indication of some underlying cause that is preventing a proper integration of the personality, and though it might be possible to change the behavior from unacceptable to acceptable, the personality will remain disintegrated unless the causes of the deviation are removed, and the child will be prevented from growing up emotionally.

Treatment lies first in a sympathetic attempt to understand the child—to understand her whole background and the reasons for that background—and to supply her emotional needs as they are revealed by this understanding. The adolescent girl needs understanding, and when she finds some one who can understand her, that person can guide her to achieve a full measure of maturity. The adolescent girl who has difficulty in the classroom, difficulty with her teacher, difficulty in her group relationships, difficulty with her parents, needs understanding rather than sentimental sympathy or correction, and it should be the duty of those who come in contact with adolescent girls—parents, deans of girls in high schools or colleges, school counselors, teachers, school physicians, and the like—to attempt to attain a better understanding of the problems of adolescence in general and of the needs and backgrounds of adolescents, and to win the confidence of the girls with whom they are associated, particularly those who show mild personality deviations, so that problems can be dealt with as they arise, not sentimentally or intuitively, but intelligently.

affection
regards

THE NUTRITIONIST LOOKS AT MENTAL HYGIENE *

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THE essentials of the beliefs that are expressed by the leaders in mental hygiene in their writings are held by nutritionists to be equally fundamental in nutrition work. The concepts of workers in both fields show likenesses in method of approach to and treatment of the causes and conditions of the patient's health, mental and physical. Further, the objective of both groups is identical—the patient's well-being, so that he may function to the best advantage in all phases of his life.

Patients come to the nutritionist exhibiting various phases of mental illness as well as dietary needs. The nutritionist, while interviewing the patient to secure the necessary data on his food habits, discovers also his attitude toward life. In planning his diet, she studies the mental, as well as the physical conditions that affect him, adjusts her treatment to his personality, and adapts the diet to his whole environment, in terms both of his individual and his group life. She studies the nature of his reaction to emotion; she gives full weight to every source of anxiety and worry; and by gaining his confidence, she helps him to overcome his more obvious repressions.

She helps him to attain the power for self-control that keeping to a diet demands, and she fosters in him the sense of self-confidence that comes with success won through faithfulness to the dietetic régime. In encouraging him to carry out his diet, she stimulates in him a sense of faith in the diet and the dietitian, and an understanding of the fundamental basis of nutrition—the relation of food to the body.

Social and other environmental conditions must always be studied and adjusted to favor the patient's success in fulfilling

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the diet prescribed. Sometimes heedless or conventional advice from the nutritionist, or the patient's unfamiliarity with his diet, or his anxiety as to the means of carrying it out, causes disharmony in his life and in the family routine when he is given a diet. More often some conflict already established before the patient's visit to the clinic counteracts the desired result of the diet. In this vicious circle both nutritionist and mental hygienist are involved. When they realize their definite relationship of interests, they act in unison for service.

True it is that the aid of the nutritionist is usually sought *merely* to supply the list of foods that will build the body in accordance with physical standards of health, that the body may carry on its various processes to this end. But if the diet is to be effective, not only physical needs, but the contributing influences of the emotional, mental, and social life, must be kept in mind. I need only refer in passing to the scientific experiments of Dr. Walter Cannon and other scientists, which so clearly demonstrate the influence of emotional disturbances upon digestion, or to the copious literature on anorexia and the "nervous child" with table tantrums. Personality and diet are linked together.

The dietitian in a clinic such as the Food Clinic of the Boston Dispensary uses the record card that comes from the medical clinic (including the face card from the admitting officer) as a means of *rapprochement*. It helps her to establish toward the patient an attitude of understanding and sympathy. Information must be acquired, but one may be saved from asking the obvious and antagonizing the patient or putting him on the defensive by being personal. The record card gives a certain amount of necessary information on which to base an intimate interview, in the course of which the questions asked are felt by the patient to be legitimate and pertinent.

Food is an integral part of the social life of the patient. It is affected by nationality, income, family traditions and habits, occupation, conditions at home, at school, in employment, and by many other factors. In turn it affects personal habits in ways that make the adjustment of the individual to the group often difficult.

The dietitian must be able to project herself into the life of the patient, to orient herself in his life—to understand, for instance, that weight is not only a matter of pounds, but a factor that may make for unhappiness, as when the child who is 15 per cent below normal is called "Skinny" or "Limpy", and his vision of becoming an athlete appears difficult of fulfillment; or when "Fatty" or "Poky"—dull-seeming, fifteen to twenty pounds overweight, yet also having aspirations—is in torture because he cannot sprint like his tormentors.

Physicians refer to the food clinic about 1,000 patients a year. They are classified according to the physical diagnosis. It is to be hoped that in the future the psychiatrist will give the nutritionist the means for a classification of mental or personality maladjustments. A few of the broad classifications, as they are found in actual cases in which maladjustments arising in home or school or employment affect the successful carrying out of the diet, are:

1. *Unhappiness* or *anxiety* from such causes as inadequate income; differences in traditions, religion, nationality, or social status; or dissatisfaction in employment or school.

2. *Fears* arising from the anticipation of disease, or from the knowledge of its presence, or from holding on apprehensively to the thought of it after the disease has been arrested, as well as other types of fear.

3. *Whims,* food fads, old wives' tales, family traditions that are slavishly adhered to or reluctantly broken.

4. *Self-indulgence,* due to lack of self-control, or to the effect of indifference to standards.

5. *Over-indulgence* on the part of the family for one of its members; particularly, over-indulgence of the child by the mother.

6. *Feelings of inferiority,* from lack of interest, imperfect stabilization of habits, dependence, or unfulfilled desires.

"It takes character to diet" and be successful. Would you know the histories of some of the patients with whom mental-hygiene objectives are given due consideration and who, under the constriction of maladjustments, must be helped and guided, with all the more subtle understanding, to carry out at home the diet planned with them in the food clinic? Per-

haps some brief histories of patients who have sought food treatment, or diet therapy, will picture most clearly to the mental hygienist the nutritionist at work in her field, and show how intimately that field is related to his own.

I often think of Mrs. B., a patient in the out-patient department of the University of California, sent to me for a diet for malnutrition and gastric disorders. I found that the diet for the physical findings must also be considered in terms of unfulfilled desires and other emotional reactions. She first asked me about myself, as she recognized in me a stranger. Then, to get necessary data, as I was unfamiliar with the dispensary record, I asked her age. Oh, no, she would not tell me that!

"All right! I asked because, by knowing height and age, I can judge what you ought to weigh."

Then, a challenge: "How old do you think I am?"

To be safe, I said, "I don't know which side of fifty."

"Don't write it down, and I'll tell you."

I promised.

"Seventy-three!"

"Impossible!"

She went on, "Because I am a teacher of music, I don't want my pupils to know my age. They would not want me."

We talked of Giescking, who had just played in the town, and then she told me why she didn't go to market or cook or eat or follow a diet. In her spare time she wished to write.

"Ah, that is what I want to do before I die!"

Then I knew that it was to the poet that I must appeal—the poet with unfulfilled desires—before food for the body could be considered, and that her mental attitude must be adjusted if I would have her give attention to the present need and meet life as it comes.

I told her that she could not write without meditation, and so I wanted her to take a quiet hour each day in the sunshine, wrap up, open the window, and look across the beautiful San Francisco Bay. Then, as the soul must have a worthy temple, she must take thought for that; she must walk, for exercise, and eat for the pure blood stream and to get the vitamines in spinach described as "imprisoned sunshine".

"Yes", she said, "I'll do it. The doctors never told me these things."

And the doctor asked, "What did you do to have her say that she would eat the things we have prescribed?"

I was sorry to think I had to leave her and come East.

"Mollie and Mary"—as I think of the child christened Mary, but called Mollie—was referred with a diagnosis of underweight. Again here was a case of lack of self-confidence and of need for adjustment in social relationships. There were no findings of organic disease, but the child vomited several times a week. We had her keep a record of food eaten and the times of vomiting. Even so, even admitting that sometimes the food seemed unusually indigestible, and after discussion with the girl, the home visitor, the foster mother, and the doctor, there was still no clew to this behavior. But alone with Mollie, we learned that she had a twin sister, a vivacious child who received a great deal of attention at home. There was no doubt that our child was the less attractive of the two. We found that she liked to come to the dispensary, for there she, too, was receiving special attention. She said once that she would like to become a nurse. Here was a clew for us. Merely to continue to urge upon Mollie the diet for underweight—to press her to drink milk, eat eggs and green vegetables, and take orange juice—was proving of little avail. But the suggestion that Mary should become a nurse for a while and take care of Mollie appealed to the girl's interest and sense of humor. Mary was to keep careful record of the food Mollie ate and the times of vomiting, and report to us each week. The scheme worked, and the diet for underweight was made effective.

He was a miserable-looking youngster, Fred B., unhappy, repressed, and shy, when he came to us with the diagnosis of underweight. He was the negation of all the mental-hygiene objectives. His mother, intelligent and seemingly of fine character, told us that Fred was not happy at home, did not want to do as she told him, quarreled with his sisters, preferred reading in the library to playing out-of-doors, and that, altogether, no one was happy with him. His food intake showed that his diet was decidedly lacking in fats, butter, and cream, which are the sources of vitamin A, in the citrous

fruits, which contain vitamin C, and in eggs and milk, which supply so many food elements necessary for the body. The family income was meager, and while the mother was willing to receive the cod-liver oil given her without charge, it was difficult to convince her that receiving food as medicine was the same thing.

After settling this embarrassing question, we began to discuss Fred's daily régime. A social worker got permission from the school to have the boy leave early, that he might have a longer noon rest period. Books were secured so that he could read at home and have his luncheon there, instead of spending his luncheon hour in the public library. There was a slight improvement, but Fred continued to be a malefactor in the home. After a good deal of questioning, we found that the boy was devoted to his father, wanted to be his helpmate in his janitor duties, and longed for his approbation. He did not like to have his sisters about, and resented it when his father took them with him, as he often did.

It was necessary then to see the father and explain to him these underlying causes of the boy's unhappiness and underweight, and there was some difficulty in moving him from his point of view that he was a good father, who always gave the boy a penny when he helped, and in convincing him that his son wanted his friendship, affection, and approval, instead of pennies, and that he must treat the boy as a pal. But the man was intelligent, and having the child's interest really at heart, said that he would try to coöperate with us. From that time things went much better, and a year later Fred was a Boy Scout, quite strong enough to be in athletics. To-day he is working full time in a factory, with a promising future, and best of all, he has outgrown the temperamental difficulties of his adolescence and is now a well-adjusted member of the family.

Little Parke D. was a charming youngster whom his mother brought to the clinic out in California. The mother had, as the clinic required, a letter from the doctor, who stated that he sent the child because the mother requested it, but that there was no nutritional problem, as the child had no organic disease. When asked why she had brought the child, the mother said, "I have listened to your lectures and have bene-

fited by them in dieting my family at home. But Parke is such a problem! He won't eat what I give him, and only eats when he wants to."

Did we have here a result of over-indulgence, lack of self-control, maladjustment in the family life? By this time the child wished to sit in his mother's lap. It was not long before he was climbing down, and then up again, his mother constantly kissing and caressing him.

It was suggested that Parke should go into the next room and play with other children there. But he didn't want to do this, and so he was placed in a little red chair, so near to his mother that he could touch her, but still distinctly separated from her. He was given playthings and told that he must stay in that chair. The conference with the mother that followed lasted three-quarters of an hour, and the child sobbed steadily all the while, not, I felt sure, from fear, but from disappointment at not being allowed to do what he wished to do.

The nutritional history that was then recorded on the specially prepared form showed that the child slept in the room with his mother and father. The latter was an invalid and quite fretful. When he got up at six in the morning, he thought that the child should get up, too. The child had no rest period during the day, and at night, although put to bed at a fairly early hour, he usually stayed awake and ran about until the older sisters went to bed. Clearly here was a case also of great fatigue. There was other testimony of self-indulgence permitted in the home. The boy might eat some of his own breakfast, but he preferred what his father had, and when not being petted at mealtime, he was being "hollered" at by the father. He ate constantly between meals, and at noon had no desire for the dinner prepared for him. He would not eat macaroni except with chopsticks. In the attempt to have him take an afternoon nap, which was usually unsuccessful, he must have a rice cake in each hand. No more need be told to indicate the maladjustment of this baby life to the health habits so vital to proper growth.

To the mother we said, "We will make out a plan of living from bedtime to bedtime, and you—not the father—must take

charge of it. You must help the child to form better sleep and play and food habits, if you want him to become a healthy person, pleasant to live with, a man whom a woman will be glad to marry. Certainly no one will find pleasure in his society if he continues as he is. Can you see what you are doing to him?"

We kept little Parke in his red chair, in spite of his tears and appeals to his mother. The child ceased crying immediately when he knew it was time for him to put his coat on to go home.

A week later the mother returned. She reported that for the first time in her life she had been boss; that she had tried to watch the daily régime of the child, making the adjustments that had been planned, and she felt that already there had been an improvement. The red chair proved a symbol. At the end of four weeks the child's food habits had improved, and he was eating a normal diet without difficulty. It was an interesting side light on this incident that the mother said it recalled to her her own childhood, and how her mother had been over-attentive to her sister, and that at the words, "See what you are doing", she realized that she would be repeating that mistake in the life of her own child if she did not change her attitude and train him in the ways of orderly association and normal independence.

A sweet-faced little old lady came to the food clinic with a question of gastric ulcer. Here showed fear, anxiety, lack of confidence. The patient appeared to be well-born and intelligent, but she was poorly clothed and evidently undernourished. The face card gave the necessary routine data, and careful questioning by the dietitian brought out the story. Bereft of home and property in the Halifax disaster, she and her husband, with her one remaining daughter and the latter's family of husband and little child, were forced to seek new means of living. Eventually they came to Boston, where her husband and son-in-law found work at good wages. But loss of employment came to destroy their comfort. The husband was laid off, the son-in-law's work became irregular, and the family was forced to move to a flat overlooking coal and railroad yards, where the son-in-law secured work at $22 a week. Moreover, the daughter had become pregnant, and having no

money for a private doctor, and being a stranger in the city, she was having no prenatal care.

This was the situation when the mother came to us for treatment, sick, undernourished, and worried over the problem of caring properly for her daughter and the baby soon to be born. Slowly she revealed to us the home conditions that were fast wearing her out. With the aid of the social-service department, she was quickly supplied with milk and cream, and money for supplementing these was given as necessary medicine. Arrangements were made for the daughter's confinement at a good free hospital. Thus relieved of a great worry, reassured concerning her own health by provision of the wherewithal for a proper diet, and with her pride unhurt, her response was quite miraculous. She began to gain immediately until she was able to assume full responsibility for caring for the family during her daughter's confinement and subsequent illness; and because, through the efforts of the social-service department, the son-in-law is now receiving more pay, we have been able to discontinue giving the milk, cream, and money.

Another patient with ulcer, a man of thirty-two, had been unemployed for four months, but his wife had been working part time, while the four children were cared for—not properly, our patient felt—by an old aunt. He was having much distress after eating, but conditions at home troubled him more than the pain. He said, "My wife and I seem to argue all the time—something we never used to do." Here the diet was definitely indicated, but would be ineffective if the social relations at home were not adjusted, if anxiety and fear were not banished, and a normal sense of independence and self-confidence reëstablished. Through the social-service department it was arranged that he should be given money from the fund of the South End Diet Kitchen to pay for the diet prescribed for him until he could find employment. After one month's treatment, he was free from pain, and then, with the aid of the social-service department, he obtained a part-time job. However, money was still given him for his diet, so that all his earnings could be used for his family. Under this arrangement his wife no longer had to work, but could again care for the children. In four months our patient had

gained twenty pounds in weight, and had regained his cheerfulness of spirit. He now has a full-time job, and there is no need of continuing to give the money for his diet.

Agnes, twenty-two years old, a stenographer earning $23 a week, with which she supported her mother and a young brother, was referred to the food clinic for underweight and constipation. On discussing her daily routine with her, we found that she stayed out late every night, and never got to bed until midnight. "If I should stay at home", she said, "I would just go crazy. I don't get along with my mother or my brother. Everything they do is wrong as far as I am concerned, and everything they do or say makes me mad." She thought that eating was a waste of time, and certainly never took enough time to eat properly.

She seemed glad to have the opportunity to tell her story, and it revealed much that needed remedying, besides the faulty diet. Again the situation showed the negative of all the objectives of mental hygiene. The core of the girl's difficulty was her unhappiness and dissatisfaction, with the resulting emotional reaction, because of her maladjustment in employment. Her job troubled her. She disliked her employer. "If I could only get away from that office", she said, "I could gain weight and everything would go well. I know I can do many things, but he gives me no responsibility. When I take dictation, he spells every word for me, as if I were a part of the typewriter. But I can't leave, because we have no money saved."

We talked over her diet and planned with her a new daily routine. She was to consider her present position as only "temporary", and not to worry about it. And she must make herself well and free of pain, to be ready for another position which would give her more satisfaction. She was given three novels to take home, that she might have reading material for evenings spent at home. The social-service department made other plans for her. She was to save a part of her weekly income, and her name was placed with several employment agencies.

She has made four visits to the food clinic, has gained ten pounds, is free from constipation, and is much happier in her work, since it is only "temporary". Her mother reports

to the social worker that Agnes is much easier to get along with at home, and that she stays at home three nights a week. She can face the present now, because she can project herself into a future in which there will be normally happy relationships.

Martin, a bright, attractive little Jewish boy, came to the clinic with his over-indulgent mother, referred by the doctor because of serious underweight. The interview disclosed that he was a "very busy" boy. The nutritional-history sheet brought out the first indication of his overcrowded life when, in reply to one of its questions, the boy said that he always ran to school. Why did he do that? The real reason became sufficiently clear. After school he went to Hebrew School for two hours, and after supper he had to study. His mother said proudly that Martin was so bright that he had been able to skip a grade. The boy said he loved to read, and the mother broke in to add that she never could get him to go out-of-doors, that he always stayed in the house to read. As she thought it was a waste of time to be unoccupied, she decided to fill up all his hours. Martin had, therefore, begun to take violin lessons, and had to practice from one to three hours a day. He practiced immediately after breakfast, so long that, not to be late at school, he had to run. At noon, dinner finished, he practiced again, and again ran to school. Consequently, not only had he very little outdoor life, but he was constantly living under high pressure. Here were the contributing factors to his underweight.

The routine of his life was talked over with his mother, and the error of giving the boy too much to do was pointed out to her. Martin became interested in the diet planned with him, and in the things that we wanted him to do to help him gain weight, and he went home determined to carry out instructions. He returned a week later, proud that he had gained two pounds. His mother had let him give up the Hebrew School, and his time after school was now spent out-of-doors. He had kept a careful record of his food and had faithfully eaten the formerly disliked fruits, vegetables, and milk.

An Italian woman was referred for obesity. Her limited knowledge of English, and the imperfect interpreting of a

young son, made the conference with her difficult. But it seemed that she was not very willing to diet. She was lovely to look at, she felt well, and why should she deny herself such innocent-seeming indulgences as bread, macaroni, and oil? However, she came regularly to the clinic, and lost weight slightly—not enough to satisfy the dietitian. Questioning revealed that she still was yielding to the temptation of the forbidden foods. A good interpreter was called, through whose medium the importance of dieting was again explained to her, and the relation of her overweight to her future good health. She said that she would try again to overcome her appetite, and aided by the previous experience, in which she had unwillingly been successful in achieving a slight loss of weight, she has since made a sincere effort, and has lost weight consistently and cheerfully.

A young policeman, married and the father of three children, was referred for duodenal ulcer. He was above the average in intelligence and background, but he was earning only a meager wage. He was worried about the upbringing of his children, worried about the cost of his diet, and worried as to how he was to carry out his diet. He was worried about everything, and was finding it difficult to adjust his life to his needs and environment. He was doing night duty, and he thought that it would be impossible for him to get the intermediate feedings prescribed for him. Through the social-service department arrangements were made with his chief whereby he was transferred to day duty. He sent his wife to the clinic to learn how to cook and serve the foods he was able to eat. She reported that he was cranky about his food, disgusted with his diet, and worried for fear he would be considered "crippled". She said that he had worked for many years on a railroad, and that there his irregular hours, poor eating habits, and worry over the impossibility of making further progress, had contributed to his present illness. For several years he had been on the police force, and recently had been transferred to a coveted position. And now that he had reached this point, he was discouraged at the thought of being physically handicapped.

The patient returned the following week. He had felt no beneficial effect from his diet. His food intake showed that

he had kept to it carefully. He said that he was unhappy in the work he was doing, that he hated day duty and thought a policeman who did day duty was an invalid or a baby. He wanted to be transferred back to night duty.

Eventually he was returned to night work. His chief stationed him as a guard in the home of a multimillionaire where milk, cream, and any food he needed were given him.

Relieved of part of the financial burden of his diet, satisfied with his work, and happy in the thought that he was not an invalid, he became symptom free and gained fifteen pounds.

These cases are enough to illustrate that the day of giving diet slips is a thing of the past, and that modern medical treatment, of which dietotherapy is a part, must consider the patient from the social and mental as well as the physical angle, and that the nutritionist must study all three and unify them in the food treatment.

We look to the mental-hygiene movement with appealing gesture, hoping that the leaders there may guide the nutritionist to greater wisdom in the treatment of her patient, that they may help her to interrelate her task more successfully with the services of other professions that are working for the development of the human being, and that they will further help to extend and vitalize this interrelationship.

The physician, the social worker, and the nurse are already close allies. In the field of dietotherapy, however, there is need of further light from psychiatry with regard to the interpretation of the mental life of patients, and the nutritionist is looking to the mental-hygiene movement for research into the nature of the relationships between food and disturbances of the emotional life.

REMARKS ON PSYCHOANALYTIC THERAPY

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PSYCHOTHERAPY has been practiced since earliest times, appearing in various guises and as often outside the medical profession as within it. Until the present century, the methods employed by medical men were largely individual. Formerly the physician interested in such matters might well be at a loss when confronted with the problem of psychological illness. He found himself approaching the matter of therapy equipped only with a few very general medical principles, and forced to rely mainly on his intuitive sense of how one person may influence another — in this instance from sickness toward health. Stern authority, kindly interest, wise counsel, "philosophies" of life, spiritual uplift, and, it must be added, a sprinkling of magic, were in various proportions contributed to the therapeutic task.

To be sure, after 1850 more systematic methods of psychotherapy were developed than had been known before; but with the exception of hypnotic suggestion, comparatively little of the work was clearly defined or in any way standardized. It should be understood that this fact in no way reflects on the efficacy of method in individual cases. It does mean, however, that until recent years psychotherapy existed mainly as an individualistic art, in small degree affected by the general scientific progress so evident in other fields of medicine. The psychotherapist still depended chiefly on his own inner resources. There was no source from which he could get orderly training, and his own ideas and special system developed from experience were too poorly formulated to enable him to teach others. However effective a physician might be in treating psychic maladies, his work bore little relationship to the past and had small influence on the future. As a rule, it began and ended with his own career in active

practice. It must be a matter of regret that the immortality given to the work of the great men of medicine in physical science and general culture could not include that part of their art of psychotherapy which must have contained common material and been based on universals.

The psychoanalytic method originated by Freud represents the most important recent development in psychotherapy. In basis this method touches principles and concepts revolutionary in character and applicable to the whole field of human psychology. In its more practical aspects, the psychoanalytic method of treatment is distinguished in many ways from other types of psychotherapy: (1) it is more nearly standardized; (2) the emotional relationship of patient to physician (so-called rapport) is understood on a far deeper level than formerly, and the recognition and manipulation of this rapport is the main agency in therapy; (3) a much less important part is played by the physician's personality in the popular sense of the term; and (4) the method is one that can be taught in theory and practice.

There are various methods of psychoanalytic treatment, all based on the same underlying principles, but differing somewhat in the superstructure of theory and the technique of application. One of these methods is the Freudian, so called from being more closely allied to that practiced and taught by Freud himself, and differing from the procedures employed by other groups of his followers, particularly the group led by Jung. In the Freudian method, the analyst keeps a relatively more detached and impersonal status. The object striven for is to aid the patient in the removal of inner obstacles to normal mental adjustments; in other words, there is an attempt to help the patient break through his repressions and bring the unconscious mental conflicts responsible for his neurosis near enough to the surface to be solved in a new and more desirable manner than before. In order not to detract from this main purpose, advice and guidance in the ordinary sense are kept at a minimum, and attention is focused on the intrapsychic life of the subject. If he needs direction and support, he can best get it elsewhere.

Jung refers to the foregoing as the "caustic method" and maintains, no doubt with good grounds, that in certain cases

more needs to be accomplished than the removal of intrapsychic obstacles. The caustic method, he considers, should apply rather exclusively to robust youth where there is plentiful opportunity ahead for satisfaction in real life. For older people, or those more limited in capacity and opportunity, he urges, as a supplement to the removal of obstacles, that treatment should be directed to mobilizing the latent resources within the self. Certain psychic potentials hitherto dwarfed and inhibited by neurotic barriers, he feels, need arousing by the leadership and inspiration of the physician. With this aid the patient will be better able to meet and satisfy the new needs and impulses released by the analysis, which from force of circumstance the outer world must in part deny. In this Jungian method, the physician must play two quite distinctive rôles. To keep the two from interfering, and, so to speak, neutralizing each other, is one of the fine problems of psychoanalytic therapy.

Among the special developments of the Freudian method is that of Rank. Rank's technique is characterized by less emphasis on the reductive and causal side, for which is required an elaborate reconstruction of the life history, and a more exclusive consideration of the working out of the rapport, or so-called transference relationship, to be discussed subsequently. One desirable result of this modification is a shortening of the duration of the treatment, which is still further reduced by having the physician rather than the patient set the date of its termination, in a sense somewhat prematurely. In the Rankian method the analyst takes a more active part, mainly in interpretation of the patient's productions (speech and attitudes) as they appear in the analysis. By such interpretations, the subject, if he accepts, is, as it were, forced progressively from stage to stage, while, in opposition, he strives to maintain various regressive and infantile levels, patterns of his poorly equipped psychic organization, now newly activated in the analytic situation. By this striving he vainly hopes to achieve in the analysis a more comfortable emotional adjustment than he had been able to find in the real world of daily living. Most of this striving and hoping goes on unconsciously and is only gradually uncovered by

the analysis as it progresses. The Rankian modification of the more typcial Freudian procedure in treatment demands, in particular, vigorous potentialities for normality on the part of the subject. It is not the method of choice for the psychologically weak or for those who are too greatly handicapped by circumstance.

The purpose in psychoanalytic therapy of whatever variety is to establish a special emotional relationship between analyst and patient which, for the time being, takes an important place in the latter's life. This relationship is called *transference*. One may turn for illustration to the absorption of the adolescent in a summer at camp, of the youth in his first year at college, or of the adult in a love affair. While the part played by an analysis may be much less obvious than these outstanding life experiences, still in a sense it takes for a period the central place in the subject's emotional life. For the neurotic, Freud calls this shifting of interests a *transference neurosis*. By this he means that difficulties and conflict, heritage and aftermath of unsolved human relationships of childhood, are transferred from the past into the present. The center of gravity, so to speak, of the subject's maladjustments are moved from the childhood past to the analytic situation of the present. In a way, this same thing occurs in all important relationships of the adult—to friend, employer, spouse, and so on. The analytical relationship differs simply in that it is so constructed as to make the transference more complete and more transparent.

The analysis is a one-sided affair, in the sense that the physician plays a relatively passive and impersonal part, and the reality situation characteristic of other contemporary relationships is at a minimum. The analyst is more a phantom figure than a real person of the present, a composite picture made up of parental images and other earlier human contacts from which the patient has never gained normal emancipation. For this reason, the age, sex, social attributes, and type of personality of the analyst play but a secondary rôle. Toward this figure of the physician in the setting of the specially created analytic situation, the subject reactivates old patterns of reaction, in a manner to become mani-

fest to him as never before, and in favorable cases there results, from a combination of desire and necessity, a reorganization of his emotional life on a new and better level.

The patient is inadequately equipped emotionally for smooth adaptation in his dealings with his fellow beings. He has childish needs and strivings, undesirable legacies from the past, which in the better adjusted person have been resolved and left behind in the process of normal psychological growth and development. The undeveloped emotional attitudes are brought by the neurotic person to all his human relationships—love, friendship, and business, as well as in wider social fields. In all of these contacts, certain of his needs are thwarted and denied. For the most part the nature of these deprivations is hidden from the individual himself and from the others with whom he deals, but none the less they hamper and complicate his attempts at adjustment. The neurotic individual constantly craves and seeks for satisfactions which the world of adult reality within or without cannot satisfy, and he is doomed to disappointment over and over repeated—all the more disturbing because he is unaware of his nature.

The patterns of emotional strivings are brought to light in analysis as they can never be in any other relationship, for reasons obvious enough. A few simple examples will illustrate. Undercurrents of hate which so often complicate for the neurotic his feelings of friendship, love, or admiration must in real life be denied expression, to say nothing of conscious realization, in order to avoid ruining an actual love relation or friendship. In an analysis the goal of self-direction and control is reversed. Instead of a premium on denial and non-realization of negative reactions, they are invited into the open. Irritation, criticism, harsh ridicule, even insult, can be brought into the analysis without affecting it in any way by the standards of social values. In a manner impossible for a person in any other situation, the analyst is emotionally untouched. He recognizes at all times that he is playing chiefly the part of a foil for the individual patient, as the qualities and traits of the latter's real self, released by the analysis, come out from behind the disguise

of the surface personality. The analyst can neither have his feelings hurt nor be flattered, he is interested only in the motives and meanings of attitudes as they are more and more freely disclosed. As another example, the dependent child-parent relationship, also present in the neurotic, would be unbearable to the more independent side of the subject, if realized by him in such a relation as to chief or employer. In the analysis, however, this can be more easily revealed, and accepted, if necessary, as part of the game, a means to an end, and not be too much a matter of humiliation.

And so it goes with all the deep-lying, repressed, dimly conscious, or unconscious emotional attitudes of the subject. Gradually in the analysis he sees them spread clearly before him. Gradually, and apparently always reluctantly, he realizes the impossibility of any straightforward satisfaction in the world of adult reality without change of his demands. Gradually, he modifies and discards some of this inadequate material for life and faces the world again after the analysis better equipped than before to adjust to things as they are, without the need of neurotic compromise.

All this is no easy task. No matter how coöperative and eager for help the neurotic patient may be on the surface, there is an underlying inertia and opposition to the mental changes that will make him well. The vigor of this resistance toward recovery brings perplexity and astonishment to the novice in the field of psychotherapy. A deeper understanding, however, makes these phenomena less obscure. Most of the psychic material involved in neurosis exists outside the realm of consciousness, and thereby is immune to the action of choice and self-direction. In fact, it is little affected in any way by logic or reason, from without or from within.

The psychic organization of the patient, with all its defects, has been constructed with a purpose—namely, to avoid pain and to hold fast to satisfactions already gained. It differs from that of the normal man only in degree. For some reason, in the childhood unconscious of the neurotic, fear of the future and reluctance to relinquish the seeming peace and security of the present have been more intense and are more determinant of the adult personality. As it stands, the plan

of the neurotic's mental life represents the habit of a lifetime, and is the result of an inner "conditioning" which gives tenacity and persistence. If from it all there has resulted for the patient conflict and maladjustment, at the same time it seems to him the least of evils as contrasted with alternatives. Less wonder, then, that he clings to his mental *status quo*, neurosis and all, as if he were threatened with the loss of something precious, or as if he were asked to give up security and plunge into a menacing unknown.

In the light of the psychoanalytic conception of the problem of neurosis, its special method of therapy becomes a systematic procedure established to accomplish certain definite ends: (1) to dislodge and recondition certain inadequate and handicapping features of the unconscious mental life; (2) to reduce the deep-lying fear and guilt that have hampered and distorted psychological growth and development; (3) to arouse a desire for independence and to force a realization of the futility of trying to appease infantile needs in an adult world—a realization that means something far more than mere intellectual understanding, and requires emotional insight and conviction; (4) last and by no mean least important, to emancipate the patient from the transference relation to the analyst. This emotional bond has furnished the central agency for accomplishing the desired changes, but carries the danger of simply shifting from an old bondage to a new one, if the dependence on the physician is held to as a way of life, rather than used as a means of therapy. The patient, through the influence of the analysis, has been persuaded to give up an emotional anchorage in his childhood past and achieve a substitute one in the analytical situation itself. A second step of even greater significance must be made. Once more he must renounce an undesirable and compromise adjustment, this time in the analysis, and be launched forth to make terms with the real world. In this world of reality, an appropriately chosen patient, his powers strengthened by the aid of the analysis, has the opportunity to make a normal adjustment as a final substitution and release, both from the childhood complications that imprisoned him in neurosis and from the experience of the analysis that has set him free.

AN EXPERIENCE WITH A STATE HOSPITAL

ANONYMOUS

PROBABLY few of you who read this article will have had the unusual experience of spending some time inside a state hospital of more than four thousand mental patients, not as a patient or a suspected case under observation, nor as a physician, nurse, or attendant, but as a guest, living for a week by courtesy of the hospital in one of the cottages with fifty patients, occupying a room lately vacated by a patient, and thus having the opportunity to observe at first hand conditions under which patients are cared for in one of the largest institutions in New York State. This experience has been mine.

You may be concluding that I was a friend of the state commissioner of mental hygiene or of the hospital superintendent or his family, or that I had been sent there to get material for this article, or that I am some highly influential person, political or otherwise, whom the hospital management was trying to impress favorably. None of these guesses is right. I am only the relative of a patient for whom the hospital has been caring for about two and a half years. During this time I have visited at the hospital at regular and irregular times, on visiting days and on non-visiting days, always remaining all day and sometimes several days. A visitor from the near-by town has also visited each week and taken the patient for motor rides when she was able to go.

At the time of a recent critical illness of the patient, I remained a week, with permission of the management, until a crisis had been passed. The superintendent and attending physician made every arrangement for my comfort. When I was not at the bedside of the patient with the special nurses assigned by the attending physician to her case, I came and went as I pleased in and about the hospital night and day without any attempt to keep me out of this corner or that

or in any way to restrict my movements. I hope you will assume that I am a more or less trustworthy person and that the management had a right to expect that I would in no way violate or abuse the privileges they had given me. I believe, however, that my experience might be paralleled by any other anxious relative under similar circumstances.

In this preamble I have been trying to establish two facts: first, that I am somewhat qualified to write of conditions as I found them and, second, that the stage was not set for me in this hospital. Indeed so little attention was paid to me by anybody that some of the patients took me for a new one among them. I can only hope that it was their lack of discrimination and not any symptoms I was manifesting that led them so to include me in their group. One inquired, sympathetically: "Did your husband send you here?" Another asked: "What part of the state do you come from?"

My relative had been a diabetic patient in eight private hospitals and sanitariums over a period of ten years. Her mental illness had been diagnosed as due to arterio-sclerosis or hardening of the arteries of the brain. While irritable and disturbed at times, she was never violent. Nevertheless, when I visited her in these private hospitals, I was frequently told that she had been given a "sedative" to quiet her when I inquired as to her dazed and stuporous condition. On one occasion I found the marks of handcuffs on this aged woman's wrists, and the nurse in charge of this particular sanitarium admitted having used them to "control" her. Diabetic diet was not adhered to or even provided in some of the places where the cost of care was fifty dollars a week in addition to doctors' bills. It was easier to keep the patient satisfied by allowing her to eat anything she asked for. Insulin was provided only at an additional cost. Only those who have experienced it can realize the financial and emotional anxieties of those ten years. The patient did not improve, the family financial resources were completely exhausted, and in utter desperation state care was resorted to, with what fear and hopelessness it would be difficult to express.

I had no facts upon which to base my impressions, but I had read and heard of the horrors to which patients under state care were subjected, and I confess now that I was among that

large group who believed that such conditions more or less universally existed in state hospitals. I was hopelessly sure that the patient would not survive two months after she passed into the state hospital's hands. She still survives at the age of seventy-five, after having recovered from two acute critical illnesses in the state hospital, and as I write, she is probably out for a motor ride.

The state hospital in question has 4,035 patients, which is 697 above its certified capacity. It is not as overcrowded as some of the metropolitan hospitals. I can best describe the superintendent in the language of another physician: "He is an intelligent, industrious fellow; knows his business and has his hand on every detail." He has surrounded himself with medical and other executive assistants of this same superior ability. There is a total number of 439 employees on the wards. We can safely assume that they are not all perfect. Unfit and undesirable employees must certainly find their way into this hospital as well as into other large groups of employed personnel, and when one considers the type of person available at the salary of the average hospital attendant, one must conclude that only constant alertness on the part of the management is responsible for the efficiency that characterizes this hospital.

This article is based upon personal observations at the receiving cottage, the hospital ward, one other ward, and the cottage in which I spent a week.

Patients are admitted at the receiving cottage and remain until classification can be made for permanent residence upon the basis of their particular illnesses. Naturally it is a difficult time for everybody concerned—for the patients, their relatives, and the hospital attachés. Patients are likely to be disturbed in these new surroundings—I can testify that their relatives are—and hospital attachés must exercise a good deal of finesse in helping to make adjustments in this first difficult step. I saw or heard no evidence of anything but kindness and careful, skillful attention to patients and consideration for their relatives at the receiving cottage.

Within a week, because of an acute diabetic condition, my relative was transferred to the hospital ward. Here again I found consideration, kindness, less mechanical treatment of

patients, and less confusion than I had experienced in private hospitals at sixty dollars a week. The nurses prepared the food in the hospital ward for those requiring special diets.

After several months, transfer was made to a ward of well-classified patients where again the food for patients who required special diets was prepared by nurses and attendants.

The final transfer was made to Cottage No. Four, where I got my real insight into the highly individual attention devoted to patients who live in this group of cottages two miles away from the main buildings.

This colony of four hundred patients consists of five cottages for women and three for men, each caring for fifty patients. They are all similar in construction and arrangement. The cottage group has branch administrative offices in charge of a skillful medical assistant superintendent, with an efficient staff of medical and nursing assistants for cottage service. The medical assistant took personal charge of my relative's case in a recent critical illness, and his careful attention resulted in what seemed almost miraculous improvement. He visited her four or five times a day for more than a week. His last call was at midnight each night, with instructions to be called in case of necessity before morning. In my many experiences of acute critical illnesses of this patient during a period of more than ten years, I had never before had a doctor offer to do that.

There are fifty patients in Cottage No. Four. So far as I could judge by living among them for a week, the classification seemed extraordinarily good. Only two became seriously disturbed during that time. I was about the house all day and up and about at all hours of the night, and there was such astonishing peace and quiet that I could scarcely realize where I was—inside a state hospital among fifty mental patients!

There are fourteen individual rooms for patients in the cottage, one of which I occupied. In addition there is one two-bed dormitory, one three-bed dormitory, and two dormitories of fifteen and sixteen beds each. Each room is furnished with a single bed, a bureau, and chairs, and some patients have a few of their individual things. Some also have wardrobes in their rooms. The bathing, toilet, and lavatory facilities are ample and are kept immaculately clean, as

indeed I found the whole cottage at all times. All food is prepared in a well-equipped kitchen. The dining-room tables were covered with white linen, and in the center of each table was a potted plant from the hospital greenhouses. The tables seat six and eight. Meals for diabetics are served at table or in their rooms as they prefer. Dainty white muslin curtains drape the southern dining-room windows, through which the sun shines all day long.

The two large solariums are comfortably furnished with easy chairs, divans, and wheel chairs. A radio has recently been installed, and either that or the victrola was in constant use.

A nurse with three attendant assistants is in charge in the daytime, and a charge attendant is on duty regularly at night. When my relative's condition required it, a special nurse was detailed to her care at night. Discipline is necessary in regulating the living together of any large groups. In Cottage No. Four, however, there was a delightful lack of rigid enforcement of inflexible institution rules and regulations and, instead, an atmosphere as near that of a normal family life as would be possible with fifty abnormal patients. They went to church or to the movies only if they wanted to go. Some of them went for long walks alone every day, unattended if they were physically able to go alone.

Lights were put out about nine o'clock, although some patients kept their lights on and read in their rooms until late into the night. The waking up of the household in the morning was interesting. At 5:30 A.M. the night attendant knocked at each door, visited each dormitory, and said: "Good morning, ladies, everybody up!" And everybody got up with less confusion than I have witnessed in the morning at getting-up time in well-regulated families. Breakfast was served at seven, and the day was begun. The housework, except laundry and cooking, is done by patients who are able to work, and the efficiency with which it is done indicates efficient management. The nurse in charge was a daily revelation to me in her quiet, calm leadership over this group of fifty abnormal women.

In ten years I had paid more than twenty-five thousand dollars for private care, which at best was never satisfactory.

In two and a half years of excellent state care I have paid thirteen hundred dollars, which includes special medical treatment by an eye, ear, nose and throat specialist, an oculist, and a skin specialist. The amount to be paid was fixed by the state mental-hygiene department. Voluntarily, a fund has been placed with the hospital steward, averaging ten dollars a month, out of which any luxuries that the patient might want could be provided. Under both plans I have always provided the patient's clothing.

One of the saddest features of my experience with the state hospital has been the neglect of patients by families and friends. Much of this attitude is doubtless due to the old impression that a certain stigma attaches to mental illness in one's family. Fortunately, a better understanding of the whole subject of mental hygiene is removing to some extent this false impression.

There is the group, too, of the violently disturbed patients for whom, according to hospital authorities, little good or comfort to the patient and much unhappiness to relatives can result from visits. But for that larger group who, in addition to their illness, are conscious of isolation and neglect by families and friends, I should like to urge more consideration and less isolation by relatives responsible for them. In a room in this state hospital lives the wife of a man and the mother of a son and daughter who bear the name of one of New York's best known families. She came to the hospital more than two years ago, and during that time she has been visited by no member of her family. Her mental disturbance is scarcely apparent to a layman. One day she said to me: "Couldn't you get my children here for Easter morning?"

Doubtless thousands of others have had my experience with private or semi-private sanitariums or hospitals, and prejudice against state care or unfavorable reports about conditions in state hospitals (frequently originating in statements of political antagonists or reports of mentally irresponsible patients) have prevented their being utilized for patients who cannot make complete recovery.

My own experience has developed in me a profound sense of gratitude to the state of New York in general and to the management of this state hospital in particular.

THE RELATION OF PSYCHIATRIC SOCIAL WORK TO PROFESSIONAL GROUPS IN PUBLIC HEALTH AGENCIES *

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SINCE 1923 there has been a gradual filtering into public-health-nursing groups of people trained as psychiatric social workers and acting as mental-hygiene supervisors, so that to-day the relation that exists between these two groups has become a matter of interest to both professions. Why did the relationship develop? What is the contribution to each profession of such a relationship? What are the difficulties present in such a relationship? What are the future possibilities of the work? These are a few of the questions asked by the leaders in both psychiatric social work and nursing. The relation of psychiatric social work to public health is that of the child to the family, for the goal of psychiatric social work *is* public health. The relation of the psychiatric social worker to professional groups in public-health agencies is like that of a newly formed stepsister alliance, an alliance of individuals divergent in make-up, which is rich in potentialities for the happy development of each, but is dependent for its permanency on the advances that each makes to the other. It is this stepsister relationship between the psychiatric social worker and the public-health nurse that is considered here.

That the nursing group would welcome such relationship seems a very natural thing to one who has considered the growth of nursing. It was only six years ago that the first psychiatric social worker joined the staff of a nursing organization. Nevertheless, the interest of the nursing group in psychiatric difficulties dates as far back as the beginning of trained nursing. The acceptance of the psychiatric social worker is only a change of method rather than the expression

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of an entirely new interest. It is true that the interest has developed. To the first desire to alleviate suffering has been added the desire to understand its nature and to know how to prevent it. The history of psychiatric social work also shows this expanding interest. In fact, social workers, tracing the development of their own work, turn back to the vigorous work of Dorothea Lynde Dix, which resulted in improved care for mentally ill patients. It is the nursing profession that claims her. It was through a representative of the nursing profession also that the first definite relationship between the medical and the social field was established. Miss Ida Cannon, in whose department at the Massachusetts General Hospital the first social worker was assigned to a nervous and mental service, was a nurse of public-health experience whose interest in mental difficulties was heightened by her work as the head of a school for the feebleminded. Not only have nurses shown an interest in psychiatric problems, but they have reached out for better understanding of their origin, and as a result, from the profession has come a literature designed to acquaint members with the field. In 1913, before there was such a person as a psychiatric social worker, a nurse, Miss May MacDonald, was chosen as executive secretary of the first society for mental hygiene, and from her interest in the work grew her book, *Mental Hygiene and the Public Health Nurse*,[1] which has become a primer for the group. Then Miss Maude Muse, recognizing the need for better training, prepared a book on psychology for nurses.[2] The demand for the third edition of this book within the first year of its publication attested to the interest that nurses throughout the country were showing in the problems of personality.

In these developments can be seen the efforts that nurses themselves have made to advance the mental-health aspect of their work. If, then, there has always been this interest in the problem, why did nurses turn to an outside group for the next stage of development? Because the training in psychiatry given to nurses was not equal to the training in

[1] Philadelphia: J. B. Lippincott Company, 1923.

[2] *A Textbook of Psychology for Nurses.* Philadelphia: W. B. Saunders Company, 1925.

psychiatry that social workers received in the schools of psychiatric social work. It was knowledge of psychiatry rather than knowledge of social work for which nurses felt a need. This conclusion is drawn because most of the organizations that now have psychiatric social workers first sought a nurse with psychiatric training rather than a psychiatric social worker, but were unable to find a person with the training they desired. Perhaps the emphasis on the psychiatric rather than the social phase may be due to the fact that many public-health courses include a small amount of field work in family case-work. The reasons for the lack of proper psychiatric training for nurses are many. The outstanding one probably is the fact that mental hospitals do not have the facilities for giving general training to nurses, and general hospitals that have training schools seldom have the opportunity for proper affiliation with psychiatric institutions. Also, the members of the medical profession have not seen the need of going to extra expense to train nurses in lines that are outside the demands of their own institutions. It has not usually been through the medical men that advancement in nurses' training has come, but rather from the demands of the community. This development is an example of that fact, since the public-health agencies are the first to insist on the correction of the lack of training.

Although it was psychiatric training that public-health-nursing associations sought in securing psychiatric social workers for their staffs, it has been found that public-health nursing has gained more from the psychiatric social worker than it could merely from additional courses in psychiatry or in family case-work. The special worker on the staff keeps the interest in the psychiatric and social phases a dynamic one rather than the static one that might exist if this interest depended merely on a few courses secured before the completion of training. The social-work aspect has meant that the nurses' interest has shifted from mental disorders to mental hygiene. For these reasons the psychiatric social worker will continue in public-health agencies until a new type of training is developed which will be a modification of psychiatric social work to meet the specific needs of a public-health agency.

The psychiatric social worker contributes, in addition to a little knowledge of psychiatric principles, a knowledge of the scope and methods of the work of other agencies. She is a factor in the harmonious relationship between the public-health agencies and the social-service agencies, because she can interpret each to the other, correct and prevent misunderstandings, and enlarge the general usefulness of both types of agencies. She also brings to the new field the benefit of her training in social work in the matter of interviewing, a knowledge needed as much by one group as by the other, but not at all developed by the nurse. A study of the principles of psychiatry is helpful to the nurse, but even more valuable is a knowledge of the resources that are available for handling the problems that arise—this last being a field which the psychiatric social worker particularly emphasizes.

Why does the nurse need the special training that a psychiatric social worker brings to an organization? The comment frequently heard is something like this: "Surely the nurse has enough to do in handling the problems for which she has had adequate training without branching into a line for which she has had little or no training and one in which there is no certainty of giving adequate aid." The fact is, however, that the physical and the mental cannot be separated. If her goal is health, good all-around health, the public-health nurse will not be content to do merely routine work if this will not lead her patient to health. The very first case that came to the mental-health supervisor's attention at Minneapolis illustrates this point.

A young man had been brought into an emergency ward with a crushed leg, and an amputation had been performed at once. He gave no history, talked to no one, refused to allow his wound to be dressed, and as soon as possible left the hospital, ignoring the instructions to return to the out-patient clinic. The visiting nurse who was called in at this stage had no difficulty in dressing the wound, but could not persuade the man to return to the hospital. Gradually the nurse drew out the story of the patient's belief that the pain in his leg was caused by a nurse at the hospital who had deliberately burned him with the electricity. An understand-

ing of the cause for the uncoöperative attitude made it easier to adjust the treatment to the patient's needs, and with the healing of the wound went also improvement in the mental condition. It is significant that it was not until the psychiatric social worker called attention to the mental-hygiene factors in the case that the nurse considered the remarks revealing his mental disorder as important enough even to record.

The nurse should understand the possibility that physical illness may affect personalities in many other ways, perhaps creating invalidism, developing unwholesome attitudes of compensation and seclusiveness, or fostering paranoid trends. Understanding this danger, the nurse should take steps to correct the earliest manifestations at the same time that she is giving her routine nursing care.

Without a knowledge of some of the psychiatric factors in the case, the nurse may even be an important factor in the continuation of the problem. This was a situation that was recently recognized by one nurse who, for months, had been going into a home of three children to see that the doctor's orders on diet and general care were followed out. Each visit left her with a greater sense of the extreme devotion and attention given the children by the paternal grandmother in whose home they were staying. The apparent desire of the grandmother for commendation of her self-sacrificing care was amply met by the nurse, who praised her on every visit and remarked on the mother's apparent lack of affection. The nurse also praised the thoughtfulness of the father in visiting the home of his mother daily to help her with her work. The temper tantrums of the little girl, which were spoken of as "just like the mother's", and the loud avowal before the grandmother which the little boy made that he would rather die than return to his mother first made the nurse look upon the problem as a possible behavior-clinic case. She, however, saw no connection between these childish problems and the adult attitudes.

When some help was given her in studying the situation, her sense of values in the case shifted astonishingly. The paternal grandfather told the story of how "something seemed to be wrong" when he and the grandmother started out to make a home together. He had quarreled at first, but had

grown weary of contention and for twenty years had been drifting into a boarder-lodger relationship which did not permit much participation in family discussions. His youngest child, the children's father, became very much the grandmother's favorite. Because of heart trouble from which the son suffered, he was given many privileges, such as staying home from school, spending extra money for amusements to compensate for his inability to enter athletics, and going unpunished for misdemeanors since excitement might overtax him. When this boy reached maturity, he married a wealthy woman's adopted daughter, six years older than himself. She had never learned to live on the small salary to which he was limited because of his heart trouble. In the difficulties that developed, the man turned again to his mother, who readily suggested that she help by taking the children into her home and who openly criticized the mother. The recital of these few facts from the many in the case quickly helped the nurse to realize that what at first seemed well merited praise might possibly be harmful, as it would only strengthen the grandmother's dominance over the new family, a dominance caused by her own need rather than that of the family. Recognition of this made the nurse understand the part that she herself played in the patient's problem, and the need that this part should be a constructive one.

The nurse's own attitude toward her patients is determined by her understanding of their mental conditions. About a year ago a nurse reported: "It just burns me up to see how Mrs. Smith sits by the door doing nothing every single time John gets sick. I told her in a polite way she was just lazy." When the mental-health supervisor made a call, she found Mrs. Smith in such a marked stage of depression that hospital care was sought immediately.

The nurse needs an understanding of mental hygiene for still another reason—the efficiency of her own work. In a profession whose training is as rigid and in which the discipline is as uncompromising as that of nursing there must necessarily arise many attitudes in regard to group relationships that cause unhappiness and that react on the quality of the work done.

The reasons why the public-health nurse needs the help

of a psychiatric social worker have been discussed. There are other reasons also for the present emphasis on mental hygiene. The nurse has definite contributions to make to psychiatric work which a worker in no other field can make. The relationship between nurse and patient creates a situation that places the nurse in a potentially constructive or destructive position in regard to the patient's welfare, according to the way the relationship is used. As in the child the physical contact of caressing and stroking calls out an emotional response, so the nurse's ministrations to the physical body create an intimate relationship resulting frequently in an outpouring of confidences, happy or tragic, annoying or amusing, which reveal many of the emotional problems of the human being. Then, too, the periods when the nurse is beside the patient are frequently periods of lowered resistance when problems in the foreground of the consciousness are told in an effort to gain poise and help. The nurse, going about her task, listening to the tale as it is poured out, allowing the quality of her work to be in no way affected by the nature of the confidences, stands in a position to sense the patient's conflicts in their unadulterated state to a degree that the social worker, calling in the home, cannot expect to attain. The nurse is the passive listener, busy in her duties, thus giving the impression of "no censure felt", which the attentiveness of a social worker sitting with idle hands cannot give. Freedom to talk, freedom to stop talking without a silence that may become embarrassing because too long, and without the danger of meeting the eyes of the social worker sitting near by, are factors in the nurse's relationship to the patient that explain the fuller confidences.

Most social workers say frankly that the public-health nurse has better contact with her clients than the social worker. Usually, however, they explain this by saying that the nurse does not have to run counter to the patient's wishes as frequently as does the social worker, and that the services of the nurse can be demonstrated more clearly. To our ears comes the repeated charge of social workers against the nurse that she is sentimental, ruled by emotion, quick to act without knowing the entire situation. What there is of truth in this statement may be due to the nurse's ignorance of the sig-

nificance of the confidences given her. Because of these confidences and because the nurse's ministrations to the patient buoy up his self-esteem, the nurse stands in a position to secure his coöperation in a plan that would fail to materialize if it were suggested by another worker whose very presence in the home wounds his independence.

There is another contribution which the nurse can make to psychiatry and that is the early recognition of problems and the securing of treatment. The psychiatric clinic, the children's court, the school, and even to a certain extent the social worker see difficulties after they are marked enough to be labeled behavior problems. The nurse, however, has the opportunity of observing normal individuals in the home from the prenatal period up to old age. The privilege of giving the young mother some conception of the principles of good mental health is a part of the prenatal instruction. The mental-hygiene problems that pregnancy presents have been brought particularly to the attention of mental-hygiene supervisors in nursing agencies because of their frequency and because of the effect on the nurse. The depression felt by many of the patients who receive free service, which is caused by the thought of another person's sharing the inadequate family income, is a vital factor, aside from the many more subtle causes of depression, and demands of the nurse, not only a recognition of the psychiatric factors involved, but a definite knowledge of social conditions in the community and some ability to teach the family how to handle more wisely the limited income that is theirs. Pregnancy is only one critical period during which the nurse is called into the home. Times of birth or death, adolescence or menopause, are all periods when psychiatric problems are revealed. The nurse frequently may prevent a problem from even arising. In fact, the most important work that she can do in mental hygiene is that which she does in her general nursing work and not the work on cases especially designated as mental-hygiene problems. The word uttered here and there which redirects a patient's interest or changes the emphasis placed on the issue is probably the most constructive part of the nursing, for it helps create a wholesome attitude in the patient toward his situation.

One may grant the soundness of the proposition that public-health nurses should know about psychiatric problems, and yet may question the wisdom of the way this knowledge is given them through a psychiatric social worker or the use to which the nurse will put this knowledge. To determine this, it would be necessary to study the actual programs now in operation. At the 1929 annual meeting of the American Association of Psychiatric Social Workers, a report was submitted showing a comparative study of the duties of the mental-hygiene supervisors in six public-health agencies.[1]

The Minneapolis Visiting Nurse Association has had a mental-hygiene supervisor for over two years. One of the first things considered as essential for the success of the work was to have two psychiatrists who could act as advisers. Recently a mental-hygiene committee, made up not only of psychiatrists, but of psychiatric social workers and representatives from the medical and family case-work fields, has been considered advisable in order that the work might be developed only along sound lines. The chief function of the psychiatric social worker in the Minneapolis plan has been educational. About 16 per cent of the supervisor's time has been spent in actual class work with the nurses and 21 per cent in conferences with individual nurses in regard to special cases. The remaining time has been used for preparation of the educational work and on direct work with cases that were too difficult for the nurses or required too much of their time. The choice of material for group discussions has been made by the supervisor with the aid of her medical advisers. The actual cases carried by the nurses have been used whenever possible to illustrate the principles under discussion. This is a method advisable in most groups, but particularly useful with a group whose entire training has been centered about concrete things. Once a year the new nurses on the staff meet for a series of classes during one hour each week. At the end of this series, the nurses are admitted to the regular weekly group discussions at the substations.

The change in the type of cases that are referred to the psychiatric social worker is an indication of the extent to

[1] Published in the *Public Health Nurse* for November, 1929.

which the teaching has been grasped. The first type of case referred is always the feebleminded, though not recognized as such by the nurses. Later, cases on which more constructive work is possible are brought to the special worker's attention. As the real causes of the problem are recognized and the sources of aid are better known, the nurses assume more responsibility, using their own initiative in doing what can be done. The record of the cases referred by each nurse, with her own statement of the problems, is a good index of her growth and ability.

There are a few obstacles to the success of a mental-hygiene project in a public-health agency, the one most frequently mentioned being the assumption that nurses as a group, because of their training or the motives that operated in their vocational selection, are too rigid, lack initiative of thought, and are not interested in intangible problems. Public-health nurses furnish less weight to these charges than any other group of nurses. If the charges are fair (and they would be difficult to prove), a definite change in the training schools is needed—a change that calls for the application of mental-hygiene principles to the schools.

Another obstacle to the success of the cases has been the lack of time that the nurses can devote to the work. Acute medical problems crowd out apparently less acute mental-hygiene problems. This of course depends on the adequacy of the staff and the importance that the nurse or her supervisor places on the mental-hygiene problem at hand. This neglect of mental-hygiene problems has been controlled to a limited extent in the Minneapolis Visiting Nurse Association by the plan of having one staff nurse who is assigned for two months to the work of the mental-health department (a longer period would be more desirable). During this time the nurse not only can gain some idea of the importance of mental-hygiene problems, but can aid in carrying out plans in those districts in which acute medical problems threaten the time spent on mental hygiene.

As the lack of time that the nurse has to devote to the cases is a serious problem, so also is the problem of the scope of work. The addition of mental hygiene to the nursing field makes the line between public-health nursing and family

case-work impossible to draw and requires the closest and friendliest type of coöperation. The training of the mental-hygiene supervisor as a social worker makes her of great value to the nursing organization in maintaining this close coöperation.

The relation of the psychiatric social worker to practicing physicians is one of the most delicate and important aspects of her work. Since it is the policy of the Visiting Nurse Association to carry beyond the second visit no case that has not a physician in attendance, the psychiatric social worker has the opportunity of correlating her work with that of the physical phase of the patient's ailment. She has the obligation of following the doctor's lead and of making clear to him the mental-hygiene problems involved as she sees them. Sometimes the general medical man has little conception of the aims of the psychiatric social worker, but is willing to work with her. The success of her work with such a doctor generally depends upon her ability to explain what type of help she needs on each case rather than upon the doctor's general knowledge of what a nurse and a psychiatric social worker can and cannot do. The medical men whose specialty is the treatment of mental-health problems have welcomed and coöperated most heartily with the psychiatric social worker who functions as mental-health supervisor in the Minneapolis Visiting Nurse Association.

A discussion of the psychiatric social worker in nursing groups should include the individual's relations to the group. What special problems does a worker from one field meet when she enters a group with different training? There are certain handicaps and certain stimulating challenges. In the first place, there is a general feeling among the nurses that a social worker cannot be effective in a nursing organization unless she has the training of a nurse. This objection can be satisfactorily met because the cases are carried only in coöperation with the nurses and therefore patients do not look for nursing attention from the special worker. The fact that she is not a nurse assures continued emphasis on mental hygiene and avoids the danger that pressure on the organization for attendance to physical illness will crowd out the equally important mental-health aspect. Another handicap

that the social worker must overcome is the suspicion that she will hold herself aloof from and feel superior to the group. This is wholly a matter of individual personalities, not of professional attitudes. The challenges to the psychiatric social worker are many and real. There is the opportunity to formulate her own knowledge so that she can give it to others. There is the opportunity of determining what knowledge is needed for the best development of public-health work. There is the chance of working with many doctors, thereby obtaining many points of view. There is the privilege of helping to correlate the various phases of public-health and social work.

The fact that both the public-health and the psychiatric social-work group have so early recognized the importance of this development and have, through their national organizations, taken steps to analyze the needs it should meet in the various localities, assures a sound growth of the relationship.

THE PSYCHIATRIC SOCIAL WORKER AS PLACEMENT SECRETARY IN AN EMPLOYMENT CENTER FOR THE HANDICAPPED

PAULINE ALSBERG

Employment Center for the Handicapped, New York City

THE Employment Center for the Handicapped came into existence as the result of a study of the twelve non-fee-charging employment agencies in New York City that serve the physically and mentally handicapped. This study was made by the Department of Industrial Studies of the Russell Sage Foundation, under the general auspices of the Welfare Council, at the request of three agencies—the Employment Bureau for the Handicapped, the Employment Department of the Institute for Crippled and Disabled, and the Vocational Service of the New York Tuberculosis and Health Association. The boards of directors of these bureaus had for some time recognized that such a survey of their work might develop possible methods of improving their service to the handicapped and of avoiding duplication, and might also bring to light phases of the problem that were not being adequately met by any one of them.

Upon the basis of this study, the committee in charge of the survey drafted a plan which resulted in the establishment of the Employment Center in July, 1927. It consists of a consolidation of the placement bureau of the Institute for Crippled and Disabled and the Employment Bureau for the Handicapped, with an extension of service to handicapped groups not cared for elsewhere. It accepts for placement all groups of handicapped men and women from New York City, except the blind, the hard of hearing, and girls and women under thirty with behavior or personality problems, which groups are served by other special bureaus.

Among the handicapped not adequately provided for were mental and neurological cases among men and boys. In order

to make a beginning at dealing with these cases, a psychiatric social worker was added to the staff to act as placement secretary for this group, as well as for women over thirty years of age with disabilities of this nature. She was first taken on for the handicapped of other types who showed serious symptoms of maladjustment. Her work was then extended to include the psychiatric and neurological groups. The service is by no means an attempt to cover all such cases in the city of New York, but is merely an experiment to determine the needs of this group and to develop a technique for meeting them. It does not include patients on parole from state hospitals, as the center has not the facilities for handling adequately this widespread and difficult community problem.

The psychiatric social worker, then, receives not only the neurotic and psychotic patients under treatment, but other handicapped applicants who are so-called "problem" cases—that is, cases in which the presenting physical disability is not, apparently, the major handicap in their work adjustment. Some have never been willing to accept suitable jobs when offered them, although they always declare that they want work; others never hold their positions long and give inadequate reasons for leaving them; still others are never able to get along with employers or co-workers. One of the first functions of the psychiatric social worker was to consider some of these maladjusted individuals who were registered with the other placement secretaries. Many of this group are not recognized definitely as psychiatric cases. There is obviously something wrong, but how do they differ from other handicapped applicants? Why are they so difficult and what is to be done about them? Most of them have no insight into their own problems; many of them do not realize that they have any.

The psychiatric social worker, after discussing the case with the referring secretary, has an interview with the applicant to determine whether the main handicap in placement is psychiatric. As few of these applicants have had a psychiatric examination, this is suggested as soon as a good contact is established. Several have admitted that they are "nervous" or maladjusted in work and none has objected to an examination. The emphasis is usually placed upon a

mutual benefit to applicant and placement secretary; the doctor will be able to help us to determine the most suitable type of work. If the applicant is not under treatment in a dispensary where there is a mental-hygiene clinic, he is referred to one of our two volunteer consultant psychiatrists for an opinion and recommendations. Some of the individuals in the referred group are mentally retarded. Most of these are transferred to the psychiatric social worker for vocational adjustment, after their mental age has been determined by a psychometric examination. If, however, the individual has found his own mental level occupationally, has a fair work record, and presents no other special adjustment problem, the referring secretary keeps the case after the initial consultation and psychological examination. The types of case accepted by the psychiatric social worker include the neurological, the glandular, the post-encephalitic, the diabetic,[1] the maladjusted, and the mentally defective (if they are under treatment for some other disability), as well as the neurotic and psychotic groups. The complicating handicap may be orthopedic, medical, cardiac, or arrested tuberculosis.

The whole approach is based upon the fundamental principles of psychiatric case-work. The first step is to secure the kind of information from which an adequate occupational plan can be developed. It was found that a special, detailed reference blank was necessary from the agencies that referred these psychiatric and neurological cases. This confidential information blank is mailed to the psychiatric social worker before the applicant reports for registration. The main points covered are: reason for referring the applicant; diagnosis (including copy of diagnosis as given by the physician in detail, noting especially present condition, persistent symptoms, and evidence of deterioration); date of onset; personality traits (such as queerness, emotional instability, irritability, suspiciousness, depression); prognosis; special precautions recommended by the physician as regards physical strain, hours, activity, responsibility; other complications and general health; attitude toward handicap; education; intelligence and vocational tests; home environment and responsibilities;

[1] This group was taken on when the psychiatric social worker first went to the Center, as her load was small.

attitude of the applicant toward members of the family and their attitude toward him; work record; attitude toward work; attitude toward employer and fellow workers. The last sheet of the form is left for comments.

With this condensed psychiatric social history as a basis for vocational adjustment, we proceed to the initial interview with the applicant. The securing of additional information for the registration card is our method of getting our first contact, and a definite effort is made to establish a good rapport and to strengthen this through sustained interest in ensuing interviews.

In many of the most difficult cases, procedure would have been impossible without the assistance of psychological and vocational tests given by our staff psychologist. These tests have been particularly valuable, too, for younger men and boys in need of a change of occupation who have been vocational, as well as social, misfits. In our vocational-guidance and selective-placement work, we have tried to evaluate the emotional as well as the intellectual aspects of the individual.

We now have our preliminary set-up—the psychiatrist's estimate of the patient in relation to employment; the important social factors that have a bearing on this, including education, training, and past work record; the applicant's choice of an occupation (if he has any); the psychological examination; the impression made by the patient upon the placement secretary, who has considered all this material, as well as its practical application to a job. With this understanding of the applicant's limitations and possibilities, as well as the possibilities and requirements of industry, our consideration now is the search for a suitable job.

Several methods are used in the search for jobs. For one thing, the want ads are gone over daily, and suitable ones are answered by telephone or mail. Our files of coöperating employers, classified by occupations and industries, are another source of securing openings. Each day many telephone calls are made to these firms, the majority of which have been investigated, in an effort to find jobs for the morning's applicants. Few direct calls are received from employers, as they are slow to realize for what jobs a handicapped person may be suitable. The confidence of one employer, who notifies

us whenever he wants to add a salesman to his force, was gained as a result of placing with him a young man who made good. He had been out of work a year, most of which time he had been at Battle Creek Sanitarium, vainly seeking a cure for a spinal-cord disease. He was a typical go-getter, and his euphoric traits were an asset in this job. His initial salary of twenty-five dollars a week was raised twice during the first six months. The next applicant hired by this employer was a psychoneurotic who had been in several ventures that failed, after losing his position as sales manager at ten thousand dollars a year. The company with which he had held this position assisted him financially for two years after his "nervous breakdown", but they felt that they could not take him back in a minor position, and he was not capable of assuming the responsibilities of his former one. The third applicant placed with this firm, a splendid-looking, capable man of sixty, looked fifteen years younger than his age, in spite of having cerebral arteriosclerosis with depression. Although the employer set his upper age limit at thirty, he gave this man a chance to get a new start.

In the running record of one case is the entry: "January 10, referred to Smith and Smith for light assembling." What are some of the events that may have preceded this simple action? If deterioration was present, it may have taken the combined efforts of the psychiatrist, the family case-worker, and the placement secretary to change the man's attitude, so that he would be willing to accept a simpler type of work than he had been doing before his illness—a job with a minimum amount of responsibility and usually a much smaller wage. Or, when the secretary offers the first job to an applicant, an unexpected resistance may manifest itself. In great excitement, he may loudly proclaim that the family worker, the doctor, and the secretary are forcing him to take unhealthy work, and that he will look over the job before he accepts it. After his voluble excitement subsides, it may take many explanations, a description of the factory, and suggestive coercion, before he will consent to apply for the job. If the applicant lacks judgment, an attempt is made to anticipate possible blunders by explaining in detail how he is to apply for this particular job. If he has an indifferent manner, an

effort is made to inject into him some enthusiasm for the work or for the concern, or the employer may be prepared for a poor approach by the explanation that the applicant has little self-confidence and makes an indifferent first impression.

It has been thought a better policy generally not to tell the employer in detail about the mental status of the applicant, but rather to emphasize the physical disability, if there is one, or to explain the situation in very general terms. Where there is no visible handicap or medical diagnosis, the prospective employer is usually told that the applicant has recovered from an illness. In many cases the employer is not interested in the nature of the handicap, although of course he knows that any applicant coming from the Center has some disability. The handicap is minimized, and the applicant's fitness for the particular job is emphasized, for the basis of constructive placement of the handicapped in industry is selecting the kind of work that the individual is able to do. Most employers would get no real understanding of the mental problem involved, even with the help of a simple interpretation, and the average employer, like the average person in the community, is so fearful of anything implying a mental condition that we feel it is necessary to undertake this educational phase of the work cautiously.

After placement, adjustment in the job is followed up. Advantage is taken of any opportunity to make this inquiry through the employer, but it is never forced. The general experience of placement bureaus for the handicapped is that the average employer who hires disabled persons feels that he has done his part and does not want to be bothered with further inquiry. The applicant is always "sold" on his fitness for the job and not on a charity basis. When a man is discharged, however, the reason for it is ascertained before an attempt is made to place him again. Much of the follow-up is done through the applicant himself. There seems to be some therapeutic value in talking over the small, irritating conditions found in most jobs, the importance of which is exaggerated for the neurotic. A new attitude toward the foreman may be established by showing the difficulties in his job, for which he is responsible to the boss; a renewed interest may be evoked by a display of interest in the details of

the process the man is performing; an antagonism directed against a co-worker may be minimized; or disadvantages in other kinds of work may help the patient to feel better satisfied with his own.

For certain types of applicants, who are in need of observation or therapy before any attempt is made to place them in industry, we have used three sheltered workshops — the Curative Workshop, the Sheltered Workroom of the Institute for Crippled and Disabled, and the Convalescent Workshop. Although these three organizations accept mental cases, no special provision is made for them; suggestions or minor adjustments are made as the facilities are available. Types of applicants that have been referred for such sheltered occupation are those who have not worked for a long period, those whose attitude toward work is doubtful, those whose ability to report on time or to work a full day is questioned, those whose occupation must be changed or of whose ability to work with their hands we are not certain. A two-weeks' period of observation gives us a concrete basis for measuring an applicant's employability or at least some indication of the type of work he is able to do.

Unfortunately, the demands of industry allow for little so-called therapeutic placement. The following is one of the rare cases in which we were able to secure curative as well as remunerative work:

> A. B., twenty-six years old, was referred to us from a mental-hygiene clinic with a diagnosis of depression, undifferentiated. He was sad, self-depreciatory, and had some difficulty in concentrating. He was intelligent, had a good personality, and was a competent stenographer. Several former employers were enthusiastic about his ability. The recommendation was for part-time work, with limited responsibility. He was placed at a tuberculosis sanitarium in the country, doing stenographic work, which required only six hours a day. At our request special arrangements were made, such as housing him with non-tuberculous employees and providing him with a garden plot. He remained nine months and returned greatly improved, speaking of his illness in the past tense. Soon after coming back to the city, he secured his own job again, which we consider one of the best proofs of a recovery.

Messenger jobs have also been used for therapeutic purposes. Many neurotics ask for outdoor work, saying that they feel better than when indoors. A number of blue-print com-

panies hire from us. The deliveries are light, seldom more than envelopes of blue prints, and the messengers have regular routes. One young man with an anxiety neurosis improved so much after a few months on a job of this kind that he was able to take up a skilled trade in an evening school. A deteriorated paretic and an applicant who is suffering from a motor aphasia due to cerebral hemorrhage have also done well at this routine work. Another job that is used as therapy for applicants in need of work, as well as for others who are unemployable in regular industry, are the candy stands in one of the parks. The company furnishes small carts, which the men wheel to a given location. The stock is also furnished, no bond is required, and there is a minimum of responsibility and strain. The men are paid on a commission basis, and the earnings depend upon the location of the stand, the weather, and, to a small extent, salesmanship. Commissions range from approximately five to forty dollars a week, the average being between ten and twelve dollars for the men in the group under discussion. A depressed, lame man, with practically no social contacts, enjoyed the school children who patronized him daily. He improved so much during a summer at a stand that he was able to return to factory work. Another applicant, a presser all his life, who could not read or write English, had developed hysterical attacks. They were so severe that he had to be taken home several times in an ambulance from the shop where he had worked many years. He worked a summer and part of the winter at a stand and was then placed with a company that runs a chain of candy stands in moving-picture theaters. He is earning eighteen dollars a week, with the prospect of adding a commission to this salary when he is transferred to a more popular theater. His employer says that he is "100 per cent". His attacks have never recurred since he began working in the park. He is apparently of border-line mentality, and could not be reached through any psychotherapy. It would be interesting if the therapeutic factors in this present occupation could be analyzed. How much has the uncomplicated environment and the absence of pressure contributed? Is it perhaps the ego satisfaction of handling money and figures, of being in a position of trust, or the outlet gained

through his contact with and service to customers, that is the secret of his adjustment?

The following case illustrates the various aspects in the vocational adjustment of a neurotic, inadequate man. It shows the persistence and time required, the therapeutic value of sheltered employment as a preliminary step to placement, the constant effort required to change the man's attitude toward work and his manner of approach when applying for a job, as well as the need for coöperation on the part of the employer.

S. R., forty-six years old, was referred by the mental-hygiene clinic of a general dispensary in June, 1927, with a diagnosis of psychoneurosis and rheumatism. He had been out of work six months. He had never been adjusted vocationally, usually working as a packer or a shipping clerk. He felt that he was too ill to work and was utterly indifferent and discouraged. He was referred to over sixteen jobs without being hired. It was then decided to send him to a sheltered workshop. He remained there two months, the family agency not deducting the small amount earned from the allowance they were giving the family. He did everything well, but insisted upon variety of work. It is practically impossible to find a job that gives variety and does not entail intricate processes or pressure, with both of which this man is unable to cope. After discharge from the workshop, he came to the attention of the psychiatric social worker. He was referred to four firms as a packer. Each time an attempt was made to inject some interest in the job or firm, to rouse him from his indifferent approach. The failure to secure the jobs was apparently not his fault.

The fifth opening was with a drug company as a packer, at twenty-two dollars a week. The employment manager reported that the man seemed uncertain whether he could do the job, but was assured of his ability and references were quoted. The applicant thought that the employment manager expected too much output. He was reminded of his unending complaints about every job and was told that he was expected to take this one and to prove to us that he could make good. He began work, and the employment manager thought that he would be too slow. We asked that he be given enough time on the job to speed up. After six weeks the report was "doing very well". The family agency, who had been assisting for eleven months, paying the rent and giving clothing to supplement the wife's earnings as a dressmaker, withdrew its aid.

After six months on the job, the man wrote us that he was afraid he was going to be laid off. The employment manager was communicated with immediately. His report that such a worker was never laid off was written to the employee. At the next monthly evening office hour, he came to talk this over. His whole bearing had changed. His walk had quickened, he spoke with confidence and related with pride how he assisted at times with foreign shipments, marking the boxes of his firm for Europe, Cuba, South America.

Up to this time no investigation had been made of this company. The visit to the employment manager was very revealing. He was personally interested in Mr. R., who, although not the fastest packer in the department, is a steady, dependable worker who "minds his own business". The rehabilitation of this employee was interpreted in terms of a man who had lost his "grip" through long illness, which had left him with the fear that he could not work. The interview ended with a request for more men like Mr. R. and a partially formulated plan to promote him to a job as checker in the department. Let no one assume, however, that Mr. R. is without complaints—of a co-worker who is prejudiced against his race and of work that is often too heavy for him. But of such stuff is the adjustment of the neurotic worker!

The problem of the man who has been out of work for years is seldom met as successfully as in the following case:

Mr. K., forty-two years old, had stayed at home for seven years, taking care of his four children, who at the time of his reference to us ranged in age from one to fifteen years. His wife was a dress operator, and when she was laid off, the family agency persuaded him to come to the Center. His psychoneurosis had begun when he had developed a duodenal ulcer, now healed. The report from the mental-hygiene clinic stated that his attitude was very much improved and that he really seemed to want work. He was an intelligent man, who had come to this country more than twenty years before from Italy, after finishing two years of high school. He had formerly been a ladies' skirt tailor, and during the war had made eighty dollars a week as a union organizer. He declared that he could not return to his trade, as constant bending was bad for his ulcer.

He was referred as a clerk to a chain-cigar-store company, but because of lack of references was not considered. He had learned to run the elevator in a settlement house, an arrangment made by the family agency to try the effect on him. He told the case-worker that it was too hard for him, but when offered such a position in a high-class apartment house, he accepted it. He began at eighty dollars a month on the following shift: alternate nights from 6 P.M. to 7 A.M. and from 6 P.M. to midnight. After three days on the job, he came in to tell the secretary that he was learning to run the switchboard. It was very evident that he was pleased, not only with the job and the superintendent, but most of all with himself. Two months later, he came in answer to a follow-up letter. He had a few minor complaints about his health and the work, but he was anticipating a raise to eighty-five dollars.

A month later, he entered a hospital for treatment of his ulcer. The superintendent replaced him before we were notified of his illness. Ten days after discharge from the hospital, he returned to his old job, the new man having disappeared the day before Christmas. The tips, which his successor was to reap (undeservedly, our applicant felt) were now his, to the amount of twenty-two dollars or more.

One of the contributing factors in the adjustment of this man was the close coöperation between the three interested

organizations — the psychiatric clinic, the family welfare agency, and the Center. The family agency waited to send Mr. K. to the clinic for his reëxamination and reference to the Center until his definite aversion to work had been largely overcome. They then continued to supply cream for his ulcer diet during the first few weeks in his new position, which in this case meant even more than their encouragement. The close working out of the details of the problem between the Center and the other responsible organization may often mean the difference between failure and adjustment for the individual. The first few days in a new job involve an intricate adjustment for such a person as Mr. K. If outside factors interfere and upset him and he loses this first position, our task and his begins once more and against greater odds.

For some individuals vocational plans can be merely palliative, not a really satisfactory adjustment. The following is a case in point:

> Daniel, twenty-one years old, was referred to the Center in December, 1927, with a diagnosis of anxiety neurosis and possible hyperthyroidism. He was also a stutterer. The previous June, he had had a hernia operation, which had been followed by this "nervous breakdown", and he had been unable to work since. Although he said that he felt as if he were in a dream, his behavior was fairly alert. His appearance and manner, somewhat effeminate, were pleasing, likely to impress an employer favorably. Since his return from Canada, two years before, he had been working as a candy clerk in a news stand for twenty-five dollars a week. The hours were from 11 A.M. to 10 P.M., and he felt that these long hours had contributed to his illness. A psychological examination showed him to be of normal mentality, with average intellectual and manual ability. He was a converted sinistral. His emotional instability was apparent throughout the tests. The recommendation was to learn a skilled trade, as his interests were of a mechanical trend.
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> He wanted outdoor work, and was placed as a messenger with a blue-print company, ten days after coming to the Center. About two months later, he entered the optical-mechanics evening course of the Institute for Crippled and Disabled. This is a skilled trade, more closely allied to an art than most trades. He chose it after a tour of the school, which offers training in jewelry making, printing, drafting, and so forth.
>
> After five months on the messenger job, he was laid off and immediately placed in the shop of a large optical company, an opportunity for which he had been waiting. He was satisfied with the salary of twelve dollars a week, because of the trade possibilities in such a shop. Two weeks later, he appeared at the office, saying that he knew that he was going to have another "breakdown". He had the same pains in his head

that had preceded the first one and he felt that he could not breathe indoors. He was urged to go back to the shop, but returned to the Center the following morning, at a time when the psychiatric social worker from the referring clinic happened to be in the office. There was quite a strong attachment to both workers. In the interview that followed, his accomplishments of the past five and a half months were emphasized, and he admitted that when he first came to the Center, he would not have thought them possible. The clinic worker walked part way to the shop with him, continuing the interview, and he told her that he would try to "conquer" because the secretary had made such an effort to find this job for him.

A month later, he reported that he was working and feeling fine. In October, he was raised to thirteen and a half dollars a week. He had joined a swimming class and was almost ready to take the life-saving test (formerly he had been afraid of water). In December, the secretary visited the employment manager to inquire about the possibilities of a raise. Daniel had been so indifferent about his work in the shop that he had been put on the elevator; the employment manager thought that a "rest" would please him. All this time, he had been doing good work in class. He had been transferred to one type of work in the shop, found it monotonous, and felt that he was not learning anything new. An attempt was made to interpret Daniel to the employment manager in terms of an anxiety neurotic, but Daniel's characteristics had no relation to "nervousness", as the manager understood it. A second attempt included a description of Daniel's social setting and some of its effects—a father who had deserted the family several times and whose whereabouts were now unknown; a mother who had supported and pampered her older child and only son; the worry that would naturally upset him at times; and the better results to be obtained from such an employee if he could be given some individual attention from an understanding foreman and an opportnity to work at different processes, if possible.

A month later, Daniel reëntered the shop. Alternate weeks were to be spent on the kind of work he particularly wanted; the other week he was to work at a practically unskilled process. The first week he was all enthusiasm, but after a few days on the second process, he complained to the employment manager that he could not continue with this arrangement; his symptoms had returned. Whereupon the employment manager told him that he could leave.

He was referred back to the clinic for a reëvaluation and further suggestions. There was a new social worker, unacquainted with the case, and the physician, without talking over the situation with Daniel, referred him to the psychologist. Further relations with the clinic seemed a waste of effort, and Daniel was seen by one of our consultant psychiatrists.

From that hour's examination we learned more about Daniel, and some of the mechanisms at work, than the clinic had given us after numerous contacts. The trade toward which he had been steered, as a result of vocational guidance, after a consideration of both his intellectual and his emotional make-up, was not the hoped-for sublimation, but a compensation, tending at times toward over-compensation. His interest

in swimming and the prowess he boasted of were apparently of the same stuff. The neurotic mechanism in this case is so deep-seated that the superficial therapy available is of questionable value. He will probably adjust better in a small shop where there is more likelihood of his being put to work on a variety of processes and of getting individual attention. Both the psychiatrist and the placement secretary feel that he is worth "taking a chance on".

Why, some may ask, do we not rely more for vocational guidance on the psychiatrist who is treating the patient? Although the following case may not represent the judgment of most physicians, it does indicate that those who are not in direct contact with industry cannot be expected to realize its demands. Especially is there a contrast between the requirements of industry and what is expected of a patient working in a department of a state hospital.

A paretic, forty-three years old, had been helping in the laboratory of one of the state hospitals for three months before he was paroled, and had been able to discharge his duties as a bottle washer very satisfactorily. The psychiatrist said that he could "do anything" except return to chauffeuring. He wanted to be a conductor on a Fifth Avenue bus, which was also approved by the doctor. We secured for him an opening in a laboratory in a large general hospital, but he was dismissed after three days because he was too slow in collecting media from the various departments and could not remember directions. He was then referred to our psychologist, who found that he was exceedingly slow in all of his mental reactions, had a poor memory, and was deteriorated in other respects. He was able to hold a messenger job with a blue-print company, which gave him a regular route. Finally, however, he refused to work overtime and was dismissed. A previous difficulty in the matter of hours had been straightened out through the secretary. The man had been stubborn with his employer, but relented after a talk with the secretary. Immediately after he lost this job, his hallucinations returned, and he reëntered the hospital.

An orthopedic applicant, whose ostensible handicap was a physical one, will illustrate more graphically the problem that was indicated in general terms in the introduction. The seriousness of the maladjustment in this orthopedic group may range from a personality problem to frank mental disease, as in the case under discussion:

Saul came to the employment department of the Institute for Crippled and Disabled in 1919, when he was eighteen years old. He walked with a decided limp, due to a paralyzed leg, the result of poliomyelitis, which he had had the year before. He had completed two years of high school and had just left a position as assistant bookkeeper, which he

had held a year. He was getting only fourteen dollars a week, and he felt that he wanted to earn more money. The employer gave him a very good reference. On first contact, he seemed stupid, but he did so well on a clerical test that the secretary decided that what seemed stupidity was lack of confidence and a peculiar personality. He was placed in factory work and in the fall returned to high school.

He did not come back until after his graduation in June, 1921, and then asked for clerical work. The secretary did not consider him a clerical type and suggested printing, but he could not afford to take up a trade. During the next six years, he had eighteen jobs. One of them he kept for ten months; many he left after two or three months or a few weeks. He was also out of work for extended periods.

He did various types of work—packing, addressing, drill and punch-press operating, assembling of switchboards, and radio sets. Some of his reasons for leaving were wages too low, offered a better job, laid off due to slack work, temporary work, and so forth. He did well on the assembling of radio condensers, and earned as much as $26.50 a week. He left a steady job for this high wage although he knew that the season at this plant was short.

In January, 1928, he was referred to the psychiatric social worker by the orthopedic secretary. He admitted that he had been a "nervous wreck a few years ago", and was now a "chronic invalid". An appointment was made with a mental-hygiene clinic and a summary was sent to them, but in the meantime he was lost track of for a few months, due to a change of address. In February he wrote that he did not see why he needed medical advice. He had had to leave three firms because they thought he was abnormal, but he did not understand how any one could take it for granted that a man was insane without investigation. He thought of suing one of these companies for damages, but did not want newspaper publicity.

He returned to the Center in June, reporting that he had been a hand addresser at a big department store for six weeks and a compiler for a "direct by mail" advertising house for two weeks. He consented to a psychiatric examination, and the report came back that he was "peculiar". Radio assembling was suggested as the type of work that he might be able to adjust to satisfactorily. A few weeks later he wrote another letter to the secretary, stating that the department-store owner had put something in the papers about him. When questioned about this, he said that something must have been in the newspapers, because every one on the street was looking at him.

He returned to the clinic, the letter preceding him. The report came back: mentally and physically inferior, but still can adjust to a job within the limits of his capacity. A job was found with a former employer, at drill press work, with which he was familiar and which he was perfectly willing to do. He was kept two days and discharged during the afternoon of the third. The employment manager explained: "He acted like an eight-year-old, and couldn't do the work." In the meantime, his sister, with whom he lived, asked the assistance of a neighborhood mental-hygiene clinic, as he refused to return to the first one. A summary of our contact was sent this clinic. The sister was immediately advised to take him to Bellevue Hospital Psychopathic Ward for observation. Provisional diagnosis: dementia praecox.

There is much food for reflection in this case. If Saul had been put in touch with a mental-hygiene clinic when he first applied for work and seemed "peculiar", could the development of the psychosis have been prevented?

Although we do not handle the problem-boy group *per se*, one is referred occasionally from a psychiatric clinic.

> David was sent with the description: an "unstable, stubborn, belligerent, dependent" eighteen-year-old. This was to be his "last chance" to make an adjustment. He had been transferred from another employment bureau as a special case. From there, he had been sent to several jobs, which he had never kept for more than four weeks. He wanted to be an electrician's helper, and had had a six months' electrical course in a trade school, in which he had done very poor work. Moreover, he looked no older than sixteen, and his childish manner did not inspire confidence.
>
> Three weeks after he registered at the Center, the bureau from which he had been transferred gave us one of their calls as a chance for David. It was the ideal combination—a small electrical contractor on the lower East Side; salary, fourteen dollars a week; hours, 9 to 6, six days a week. (David was satisfied if he had Sunday free.) After being there four months, he was raised to $16. His boss supervises each job he is sent on. The key to David's adjustment is best expressed in his own words: "I never was interested in any job I ever had, except this one." It is perhaps superfluous to add that David liked his boss from the first.

Before concluding, we would like to mention some of the more perplexing problems that confront us. One of the serious difficulties in the way of more effective and constructive work is the lack of a sheltered workshop for psychiatric cases. Such a workshop has several functions: it provides therapeutic work for those too ill to return to industry without a transition period; it offers prolonged or permanent sheltered employment for others, who are incapable of meeting the demands of industry; and it gives an opportunity for the observation of applicants before attempt is made to place them. Although the psychological examinations partially meet this latter need, they cannot tell us certain important factors, such as an individual's work tolerance, production rate on an eight-hour schedule, and the like. More practical psychological tests could be set up in a workshop of this type than in an office. It would require, of course, a personnel trained in the handling of mental patients. It implies,

too, the closest coöperation between the placement bureau and the organization responsible for the shop.

Another community problem that affects our placement is the lack of free evening psychiatric clinics. The only ones available at present are those connected with family agencies and the clinic of the Cornell Medical School, which is a pay clinic. If therapy could parallel the adjusting in a job, how much more effective that adjustment would be. We realize it is but one part of the whole adaptation of the individual, but it often is the path from which branch out smoother and straighter byways, if the path is well selected. Most of our applicants are cut off from psychiatric treatment as soon as they begin work, because they cannot get off during clinic hours.

Some of the psychiatrists and a few of the psychiatric social workers do not seem to realize the importance of giving adequate information about the patient. Without an understanding of the applicant, vocational adjustment or placement cannot be undertaken. Our office interviews cannot be inclusive, nor can we rely upon the applicant himself to give us the data from which to work. The referring agency must be depended upon to furnish as many facts as are available and to continue the burden of psychiatric treatment and case-work as indicated. In discussing the responsibility of case-workers, Miss Marcus[1] points out that the case-worker often consciously and inevitably assumes responsibility in the treatment of personality and behavior difficulties as the essential problems of her job. Such a situation is inherent in the quick process of placement. However, it is felt that the placement secretary is often forced to assume responsibilities that rightfully belong to the psychiatrist or the case-worker. The average psychiatric clinic lacks time and facilities for even the study and treatment possible within clinical limitations, as Miss Marcus further indicates.[2] The occupational adjustment is of necessity affected by these existing conditions. The complex problem of integrating the work of psy-

[1] *Some Aspects of Relief in Family Case-work*, by Grace F. Marcus. New York: Charity Organization Society of New York City, 1929. p. 96.

[2] *Ibid.*, p. 93.

chiatrist, case-worker, and placement secretary might be accomplished by establishing an informal "occupational clinic". Here the interrelationship of these three to the patient might be worked out together, more intelligently and with better end results. As a part of this, job analyses and individual classifications of both jobs and patients might be undertaken. "Light work", now undefined and therefore recommended without any helpful interpretation from the physician, might be clarified in definite industrial and medical terminology.

A better understanding of the whole problem of the adjustment of individuals to work might result if some of the so-called successful cases among our group could be analyzed and evaluated by a psychiatrist who has some industrial background and interest. This would probably mean intensive work with the individual. Analysis is not used here in the sense of psychoanalysis, although there is a need for a psychoanalytic clinic for persons of moderate means, with evening hours, where some of our more intelligent applicants might be accepted and the findings relayed to us. These data could then be used as a basis for further research and for working out better methods of vocational adjustment.

PSYCHOTHERAPEUTIC PROCEDURE IN THE TREATMENT OF CHRONIC ALCOHOLISM *

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IN the use of alcohol as a beverage there is a descending scale of mental as well as physical reaction, increasingly pathological, beginning with almost total abstinence and ending with delirium tremens, alcoholic dementia, and death. Just where on this scale chronic alcoholism begins is open to a variety of opinion, but for practical working purposes I draw the dividing line between those to whom a night's sleep habitually represents the end of an alcoholic occasion and those to whom it is only an unusually long period of abstention. The former class, which will be referred to as normal, includes the man who limits himself to a casual glass of beer, as well as the man who is intoxicated every evening. But at worst they are hard drinkers, going soberly about their business in the daytime, seeking escape from social rather than subjective suppressions, and to be definitely distinguished from the morning drinkers who are, to all intents and purposes, chronic alcoholics, inebriates, or drunkards. There are normal men who occasionally indulge in a premeditated debauch, and who sometimes start the next day with a drink; but by and large, the men who can drink and remain psychologically integrated avoid it the next day until evening (midday social events excepted).

At first glance such a division would seem to be a quantitative one, but I believe this would be a superficial judgment. In reality there is a clearly defined qualitative mental reaction

* Read before the Boston Society of Psychiatry and Neurology, April 18, 1928, and before the Harvard Psychological Clinic, December 14, 1928. The treatment outlined in this article has been carried on by Courtenay Baylor for seventeen years. I can never sufficiently acknowledge my debt to him for my ability to write it. In rewriting the paper helpful suggestions were received from Dr. G. C. Caner, Dr. H. A. Murray, Dr. Martin W. Peck, and Dr. Morton Prince.

in chronic alcoholism, more closely associated with narcotics than with the normal use of alcohol.

It does not appear that the original impulse to drink is much, if any, stronger in the chronic alcoholic than it is in the hard drinker, and I believe that the latter would have almost as much difficulty in giving up his habit in spite of his boasting to the contrary; but when it comes to stopping temporarily, the situation is entirely different. Once he has entered into it, the drunkard has a pathological dread of leaving the alcoholic state.

A man said to me the other day, "That first drink in the morning is the best of all. It makes you feel as if you were coming back to sanity." Normal drinkers know nothing of such an experience as that.

So it is with the individuals to whom alcohol has become a narcotic that this article is concerned.

II

Of course people are not born drunkards, except potentially. Havelock Ellis states that it is no easy matter to make a drunkard out of the average man. The transition is often subtle and slow. It may take place within a year of the initial indulgence or it may be postponed for twenty years. The first definite and generally fatal step is taken when the discovery is made that the mind rather than the body is suffering from alcoholic excess, and that a drink is good medicine for this mental suffering. A man then conceives the idea that he can avoid a nervous depression which he has become too cowardly to face. If he originally felt the necessity to escape from reality by getting intoxicated, reality plus a "hangover" must be avoided at all costs. I do not believe that the average alcoholic wants to remain in a state of intoxication, in the same sense, at any rate, that he wanted to drink in the beginning. He is constantly rationalizing that he is "tapering off" and is seldom enjoying his spree after the first or second day; but he cannot stand the nervousness and depression that set in when the narcotic is stopped or even cut down. He talks of "needing" a drink rather than of "wanting" one, and when a man "needs" alcohol, he has definitely reached a pathological stage of drinking.

III

The behavior of the alcoholic is, I believe, better explained as an abnormal search for ego maximation or self-preservation than in terms of repressed libido—using libido in the Freudian sense. There is invariably an inordinate craving for power in an organism that has proved totally incapable of realizing its cravings. The alcoholic state takes on the aspect of a simple wish-fulfilment dream. For the time being—*i.e.*, while drinking—the individual has caught up with his imagination. In fact, much can be learned about him by asking him to describe what constitutes to his mind an ideal debauch. On the other hand, mental analyses have rarely disclosed anything abnormal or suppressed in the conscious sex lives of the patients, though I realize that psychoanalysis has uncovered strong evidence of latent homosexuality in the unconscious minds of alcoholics.[1] There is almost always, however, some degree of inferiority feeling and often it is extreme. It is a separate and more fundamental inadequacy than that which alcoholic misconduct itself creates, though dissipation and shame form such an exceedingly vicious circle that the whole problem on the surface seems confined to the symptom itself. The alcoholic is often unconsciously glad of what he considers a manly excuse to escape his responsibilities and conceal his weakness. A sober ineffective personality is unbearable, but there is something heroic about a drunkard. So he regresses to an infantile state of irresponsibility in which he imagines himself to be safe, and it is this regressive factor that accounts, I think, for much of the childish behavior in those under the influence of liquor.

Originally I tried to explain alcoholism in terms of extroversion and introversion—*i.e.*, as a disease of introversion. There were enough alcoholic extroverts, however, to make such a position untenable, further than to say that alcoholics who are predominantly introverted outnumber the extroverted by three or four to one.

To digress slightly, while I agree with Professor McDougall that the introvert drinks to extrovert himself, I must add that the extrovert drinks for the same reason—that is, further to

[1] See *Peculiarities of Behavior*, by Wilhelm Stekel. Authorized translation by James S. Van Teslaar. New York: Boni and Liveright, 1924. Vol. I, chapter 4.

extrovert himself, but I disagree with McDougall when he says that a person is hard-headed in withstanding the effects of alcohol in proportion as he is introverted. Better to say that he is light-headed in proportion to his psychological disintegration.

In searching for causes, it is necessary to distinguish between those that merely influence the individual to take up drinking and those that make him a chronic alcoholic. The former are too obvious and of too little interest to be a part of this article. As for the latter, the question of inheritance naturally arises first. I do not believe and have never seen it stated that the direct craving for alcohol was transmitted from one generation to another. In nearly every case, however, my patients have referred to at least one of their parents as being nervous or temperamental, and often their abnormal behavior seems to have been extreme. Therefore, we can reasonably say, it seems to me, that a nervous system that cannot function properly under alcoholic stimulation is definitely inherited, but that is as far as we can hold the parents responsible, genetically speaking, regardless of their habits.

Much more important is the early home environment. It is difficult to say just what part an alcoholic setting plays in the formation of the child's character. My own theory is that it is of less importance than one would imagine. It may influence him to drink when he matures, but his tendency to pathological drinking depends on whether he has been taught to believe in and rely on himself or whether he has been frightened, neglected, or pampered, thereby growing up inadequately adjusted to his environment, with attending feelings of inferiority. Cases of chronic alcoholism in which the parental attitude toward the child was intelligent are rare; more frequently it was decidedly abnormal. Where exceptions to this theory have been noted, I must confess I have been at a loss to explain the etiology of the habit.

IV

The reason we so seldom find alcoholism combined with a pronounced phobia, hysteria, or compulsion is, I think,

because alcoholism has fortuitously occurred as a symptom of an underlying condition which might just as well have been expressed in another kind of neurosis. If, as Freud says, the neurosis is the negative of a perversion, I do not see why it would not be equally truthful to say that chronic alcoholism is the negative of a neurosis.

I say fortuitously, but as a matter of fact it is a rather natural method of escape from disturbing conflicts because it is arrived at by a quasi-normal route. An alcoholic is only doing in an exaggerated way what a large portion of the normal male public has done for centuries, and he is not conscious of his pathological condition until its symptomatic expression is fully developed.

While chronic alcoholism is just as definitely a symptom of an abnormal mental condition as claustrophobia, the analysis of alcoholics as a group brings out different states of mind from those found in more commonly recognized psychoneurotic conditions.

For instance, that exaggerated concentration on self which characterizes most neurotics is much less apparent in alcoholics. They are more interested in life objectively, even though this interest may be of a non-participating nature. A very large majority are intellectually as well as morally honest. (Incidentally, where they are not morally honest when sober, the prognosis is exceedingly unfavorable.) While they are less fearful of their condition, they are far less courageous in their efforts to overcome it. If the average alcoholic had half the bravery and perseverance of the average neurotic, his problem would soon be a thing of the past. This statement is made because of the apparent ease with which the inebriate indulges himself, once his mind is made up. There seems rarely, if ever, to be that heroic struggle so often found in those suffering from the various psychoneuroses. The point of view is merely changed and action automatically follows. That is why, in the treatment of alcoholism, the mental synthesis must be stressed in contrast to the analysis that has proved so important in the more typical neuroses.

V

Once a man has become a drunkard, it is no easy matter to rehabilitate him even under the best conditions. It takes at least fifty and generally nearer one hundred hours of work on the part of the instructor and an almost perpetual concentration on the part of the subject. He is taking a course in mental reorganization and he must never forget it. Therefore, certain types can be eliminated as unsuitable for treatment. This includes those who are in any way psychotic, as well as those who wish to recover temporarily for some ulterior motive, as, for instance, the pacification of irate parents by sons eager for an opportunity to renew their excesses, or of discouraged wives by husbands anxious to keep out of the divorce court. Another futile group are those who wish to be taught to "drink like gentlemen", as the saying goes. There is only one thing a drunkard can be taught and that is complete abstention forever, and it is only to those who are sincere and intelligent enough to comprehend this that the treatment is applicable.

Between the sane, sincere group and that just referred to there exists a rather large number of people for whom the prognosis is most uncertain, further than to say that a cure will be effected only after a very long and discouraging course of treatment, if at all. This group I can only designate by those vague terms "constitutional inferior", "psychopathic personality", and "peculiar personality". These people are obviously sane and in their own way sincere, but they never have been well integrated even before they indulged in alcohol. They seem to lack sufficient driving force (libido as the word is used by Jung) to sustain any plan of constructive thought or action long enough to have it crystallize into permanently fixed habits. Even though rarely cured in the strictest sense of the word, the alcoholic outbreaks of these individuals are often restricted to relative infrequency if they are kept under more or less permanent supervision.

VI

Before describing what the treatment is, mention should be made of one thing that it is not, and that is ethical exhorta-

tion. Patients have invariably been surfeited with preaching, and they must be reached by some new approach if their attention is to be gained and held. Appeals to their self-respect, warnings as to future mental and physical disasters seldom do any good. Nor are patients encouraged to give up their habit for the benefit of anybody else. It may strike a romantic note in the beginning, but sooner or later the person for whom it is given up does something or is imagined to have done something which gives unconsciously the longed for excuse to drink. The patient's problem is to overcome his habit because he himself believes it to be the expedient thing to do.

There have been cases where the individual has been persuaded that he wanted to stop drinking as well as shown how to do it, but it is more satisfactory to deal with people whose moral problems have been previously settled.

VII

The treatment may be subdivided as follows: (1) analysis; (2) relaxation and suggestion; (3) auto-relaxation and auto-suggestion; (4) general discussion, which might be called persuasion in the manner of Dubois or readjustment after McDougall; (5) outside reading; (6) development where possible of one or more interests or hobbies; (7) exercise; (8) operating on a daily schedule; (9) thought direction and thought control in the conscious mind.

On the first interview, I try to gain the confidence of the patient by showing him that his pathological drinking is thoroughly understood and that he is not going to be treated by prayer or abuse.

The patient is encouraged to give a full account of his past history and present situation. I try to make the analysis as thorough as possible, but do not go into the unconscious. There are cases of compulsive periodic dipsomania which would unquestionably require a psychoanalysis, but I have not met one of them yet. Stekel, I believe, is authority for the statement that psychoanalysis should be used only when other methods have failed. As many worries as can be are removed by helping the patient to come to definite decisions,

or at least partially relieved by making as concrete plans as possible. Some conflicts tend to disappear under confession, discussion, and explanation, and many more are considerably diminished. This is a most necessary preliminary, but only a preliminary to the work.

VIII

The second phase of treatment, relaxation and suggestion, is, as far as I can determine, what Boris Sidis has called hypnoidal suggestion, and has referred to as being particularly effective in the treatment of alcoholism. The patient is put into a state of abstraction. He is asked to close his eyes, breathe slowly, and think of the more prominent muscles when they are mentioned as becoming relaxed. The cadence of the voice is made increasingly monotonous, ending with the suggestion that the patient is drowsier and sleepier. This lasts for five minutes, and then an equal amount of time is spent in giving simple constructive ideas.

Most important also is the application of the same measures by the individual himself before going to sleep at night. Ideas that occupy the mind at that time have a particularly effective influence on the thoughts and actions of the succeeding day.

The importance of this part of the treatment is all out of proportion in its effect to the time that it takes. Not only does it have a direct bearing on alcoholism, but it gives the patient a method of control that is extremely helpful in creating other changes in his personality, once his habit has been conquered. In other words, the alcoholic habit being only a symptom, its removal is only a part of the work. Treatment of the underlying conditions reorganizes the entire character, with benefits extending far beyond the negative one of alcoholic abstention.

While on the subject of relaxation, which has been considered in its application for the purpose of influencing the unconscious mind—that is, in a special sense—I might add that it has a general bearing on the immediate causes of drinking. Courtenay Baylor in an excellent little book called *Remaking a Man,* now unhappily out of print, sets forth as his central theme the idea that drinking before all else gives

an artificial release from a tense state of mind, and when this mental tenseness is removed, the apparent necessity for drinking disappears.

It is undeniable that two definite states of mind are sought after by the drinker—calmness and happiness. The childish pleasure that the alcoholic attains in the early stages of intoxication can be easily dispensed with when the desire to give up drinking is genuine, but the relief from nervous tension is a different matter. When a person has been taught relaxation, he is treating the immediate cause rather than the symptom itself, which is the first step in removing the primary conscious cause—*i.e.*, the feelings of inferiority and fear. The imagined fascination of alcohol lies in the fact that it is a stimulant and a narcotic at the same time, psychologically speaking. In other words, drink soothes as it elates and it elates largely because it soothes—*i.e.*, relaxes. Barbitol will soothe, but in a purely negative manner and without any accompanying idea of elation. Strychnine and coffee will stimulate, but with so much nervous excitation that their stimulation has little relationship to escape from reality. Alcohol in the preliminary stages produces simultaneously the two longed for states of mind in a way that is unfortunately most seductive to those who can the least afford artificial stimulation or relaxation.

It is an interesting point that alcoholics as a class, no matter how cynical they may be, respond to relaxation even more enthusiastically than other neurotics, though it would seem that the latter were more in need of it and therefore would be more impressed by it.

IX

Development of new interests is obviously a most important part of any therapeutic treatment. The only way to remove destructive ideas from a person's mind is to introduce constructive ones. For a man to occupy himself solely with the thought that he is not going to drink would be such a sterile performance that it would probably not be true, for long at any rate. An alcoholic has one idea of pleasure, and it is of the greatest importance that he discover as soon

as possible that he can enjoy life in many ways outside of intoxication if he will lift himself to a more intelligent plane of thought and action. Furthermore, a drunkard has little by little withdrawn himself from his natural environment, his acquaintance is apt to be with the dregs of society, and drunk or sober, his constructive interest in things of any value is nil. He must be made to reach out in many different directions to divert himself from his former negative stereotyped habits.

The reason that long periods of being on the conventional "water wagon" have not changed a man's point of view is because the idea of eventual indulgence has kept the alcoholic conflict alive and thus prevented the creative urge from becoming attached to some worth-while interest. It is essential that this normal urge be given adequate expression. Where it is inhibited through fear or laziness, its force is not extinguished, but turned inward, creating a conflict which symbolically expresses itself in fear, worry, or boredom. Thus a mental situation is produced that needs to be soothed and forgotten, and it is perfectly obvious how the alcoholic is going to soothe and forget it. Until he rearranges his life so that he no longer perpetually craves to escape from this inner turmoil, he feels that he is up against a temptation which he cannot resist, though he thinks of the temptation as an entity in itself and not as a symbolic defense against an underlying mental condition. The creative urge must be legitimately satisfied. Jung, referring to neurotics in his essay *The Ego and the Unconscious,* remarks: "As a result of their narrow conscious outlook and their too limited existence, they spend too little energy. The unused surplus gradually accumulates in the unconscious, and finally explodes in the form of a more or less acute neurosis." For "neurosis" I think we could substitute "debauch" without changing the validity of the statement.

While on the subject of interest development, a case recently finished might be mentioned in which the patient was encouraged to develop his literary proclivities. One night, while writing an essay, he became so absorbed in his work that he experienced the same vital intensity that he had found previously only in intoxication, and he stayed awake until

four o'clock in the morning to finish it. I felt then for the first time that sooner or later he would be cured. It proved to be true. In a short time he obtained research work in a library and supplemented that by writing book reviews for the newspapers. As he expressed it, "I am enjoying life for the first time without rum."

One method, obviously, of arousing a normal interest is reading. There is a short list of books that patients are asked to read carefully, marking the passages that appeal to them. These passages are later copied into a notebook along with some typewritten sheets that are given them, the most important of which I shall outline when I come to the subject of persuasion. These books are self-help essays of a practical rather than a religious or sentimental nature. Arnold Bennett's *Human Machine,* Coster's *Psychoanalysis for Normal People,* and James's monograph on habit are typical examples.

X

The importance of a reasonable amount of exercise each day, as well as obedience to the ordinary rules of hygiene, cannot be overemphasized. A mind can function properly only in a well-regulated body, and an alcoholic in process of reorganization needs to have his mind function as near 100 per cent properly as he can all the time.

While on the subject of hygiene, I might add that precautions are taken to find out if the individual is as physically healthy as possible, and if he has not recently been examined, he is urged to get in touch with his physician. At any rate, I disclaim all responsibility on the physical side and never under any circumstances suggest even the simplest medicines.

XI

We now come to the most important phase of the treatment, the central feature to which all others are expected to contribute. That is thought direction and control. A person literally thinks himself out of his alcoholic habit, and his ability permanently to control or direct his thoughts is the determining factor in his success or failure. A drunkard is invariably lost when he takes his first drink, or perhaps it

would be better to say when the determining thought to take the drink becomes crystallized in his mind. Back of this thought are a long series of thoughts leading up to it, which, had they existed in opposite form, would have produced correspondingly different action.

As one alcoholic expressed it, "Sometimes I actually find myself at the bootlegger's almost without knowing how I got there, and without, I am sure, intending to go there." When I showed him his habitual thought processes, he readily saw how this apparent somnambulism had taken place.

To be more explicit, patients are advised to divert their minds as much as possible from the whole subject of drinking. When this diversion amounts to downright suppression—when it is impossible of accomplishment, as is always the case in the beginning—then they are most emphatically told to think of the subject in its entirety, as it exists in fact. If they are reflecting on some "wonderful party" that they have had, then they must pursue it to its conclusion, and recall as vividly as possible the remorse, the sickness, and the trouble that came after it, bringing the question down to the present time. Before leaving the subject, they must have a complete view of the whole dismal picture. Nothing is more harmful than thinking or daydreaming in the past, present, or future on the pleasant side of alcoholic excesses. Whereas, if the alcoholic will review the entire scene, he will reject the dangerous suggestion that alcohol produces a truly pleasurable occasion.

Some drinkers give up trying to justify their behavior, but the reasoning processes of the great majority are a series of rationalizations. The excuses range from inheritance to a cold in the head, and they are all equally futile. The alcoholic must understand that there are no excuses for his taking even one glass of beer. If a man takes a drink, it is because he wants to take it and not because he is impelled to do so by some exterior event.

XII

The following ideas form the substance of what I have designated as discussion or persuasion. These thoughts are

repeated over and over again to the patient in one form or another.

The first thing to impress on his mind is the fact that he is a drunkard and as such to be definitely distinguished from his moderate or even hard-drinking friends; furthermore, that he can never successfully drink anything containing alcohol. These points have been already explained, as has thought direction and control.

XIII

In spite of much pretense, no work of a serious nature is ever accomplished until the alcoholic surrenders completely to the fact just mentioned in regard to never drinking alcohol in any form or quantity. This surrender to its full depth is apt to be a difficult thing to accomplish because of the interference of a distorted pride. A man who is bold enough to enter a condition that he knows is disgracing him is ashamed to admit to himself and to his friends that he has given up the cause of his disgrace. On three occasions this year I have made inquiry into the sudden favorable change of attitude on the part of the patient, and each time I received the answer, "Well, I really never made up my mind to stop for good before. I never really gave up the idea that I couldn't and wouldn't drink some day in the distant future." My reply to this is that one attitude toward drinking which at first seems reasonable, but which from long experience has proved to be disastrous, is that of stopping for only a limited period of time, no matter how long that period may be. If a person could refrain from drinking for five years while diligently reconstructing his thought processes, it would be sufficient. Unfortunately it has been thoroughly proven that five years can and does become five minutes under emotional excitement in a manner that would seem impossible in moments of calm reasoning.

XIV

While the theory of treatment is not predicated on will power except in so far as it applies to carrying out instruc-

tions, it is necessary that the will be used in the early stages while the new methods are getting thought power upon its feet. Obviously, new ideas cannot make much headway in a mind that is constantly befuddled with alcohol. Because in the long run people tend to do as they wish, will power sooner or later loses in the conflict with desire. Win or lose, a perpetual conflict in the mind is almost as much of a handicap as its outward expression in a habit. The proper control of thinking, therefore, must be established to obviate the necessity for will power by redirecting the psychic processes.

The greatest difficulty in trying to accomplish this is to find enough things for patients to do when they are absent from the office. They should consider that they are taking a course, but because of the simplicity of the work it is difficult for them to keep their mind on the seriousness of what they are doing.

It is impressed upon them that they must play the part of self-instructor as well as of student. It is really this instructor element in them that stimulated their interest in the beginning, and they must continue to coöperate with me and not expect that I can do all the work with them in the rôle of passive listeners. Regardless of their past record, they must be made to feel as self-reliant as possible, for in the last analysis it is they who must reorganize themselves while I am only their associate instructor. The reverse of this necessary self-reliant attitude is, of course, the main argument against confining a person to an institution. He is sober there because he cannot be otherwise. His power of choice is removed by compulsion, with attending humiliation. Incarceration should never be employed until everything else has failed and the desperateness of the situation requires that society be considered first and the individual second. A situation in which careful physical supervision is necessary to enable a man to recuperate from long continued excesses would of course constitute an exception to this statement. Where the individual willingly goes to an institution as a means of checking an irresistible compulsion to drink, the effect is entirely different—*i.e.*, beneficial.

XV

It has been found that a most useful aid to reintegration is to make out a schedule each evening and then follow it faithfully the next day. It prevents idleness, assists in making the work concrete, and, what is most important, trains the individual to execute his own commands. If a person cannot do simple things on time and in the manner planned, he has little chance of overcoming his major temptation. If, on the other hand, he forms the habit of carrying out his own instructions, he creates thereby a disciplined will and an executive state of mind, so that when the idea of drinking comes to his attention, there is every chance of its being diverted. An alcoholic is a specialist at avoiding life, but as it is rarely his fundamental philsophy to do so, he is in a constant state of conflict and dissatisfaction; so it is our first duty to build up a morale that will take care of normal responsibilities and give him a legitimate feeling of power. Incidentally, a schedule discloses the limits of laziness and insincerity. When you find a subject who will not and cannot keep a schedule that he makes himself, with the understanding that it can always be changed for honest reasons, you can be pretty sure that you are going to be unsuccessful with him until he changes his attitude, and you may be somewhat skeptical that he can change it.

Wise planning is a most important preliminary to a course of conduct, and for most people it is comparatively easy. But the majority of alcoholics, in common with neurotics, find the execution of a plan difficult, even though to a normal person the plan itself may seem short and simple. As William James has stated in his essay on habit, once a course of action has been determined upon, execute it. This applies to the small things of the alcoholic's life as well as the central theme. Many nervous troubles have as a common denominator exaggerated introspection, and the greatest defense against this weakness is sustained action. The alcoholic must be able to observe concrete, positive results of his efforts as a means of maintaining his interest in the work.

XVI

Of the various methods discussed for combating chronic alcoholism, it is impossible as well as unnecessary to say which is the most or the least important. That would vary with the individual. Each element has its place, and it would not be fair to several of the elements if one or two were neglected. The surest way to prolong the work is to avoid the more distasteful part and then become depressed because the rest of it does not produce better results.

In no case where a relapse has occurred has it been found that a person has been coöperating conscientiously. In fact the usual answer to my query is, "Yes, I must admit that I have only been making about half an effort. I thought I was going ahead all right and didn't need it." To which I reply that he is getting out of the work just what he put into it, and that the same ratio will continue in the future. Hard, faithful work cannot be avoided, as the habitual thinking of many years is not going to be reversed in a month or two.

After certain progress has been made, there is one bit of sophistry that the alcoholic has to guard against, and that is the idea that he is entitled to a vacation. He knows that he has shown improvement, so he imagines that if he falls temporarily, those who are interested in him will still feel encouraged, and such action will not prove fatal to the eventual cure. There is enough truth to this reasoning to make it a serious impediment to recovery if it is acted upon.

XVII

Much of this persuasion obviously aims at prevention through anticipation. Difficulties of which one is forewarned are not apt to be so dangerous where one is sincerely desirous of embarking on a new course of behavior. In this connection there are three points that I wish to bring out.

It is generally understood that the best excuses for drinking are those of an unpleasant emotional nature—anger, worry, and sorrow. It is not so well recognized, but equally true, that the pleasant emotions have just as contagious an effect and in many cases more so. An alcoholic has to

learn to face success with the same fortitude, strange as it may seem, as he does disaster. Any emotional stimulation has to be guarded from spreading into the alcoholic sphere in order to avoid the return to humdrum reality. It is only when reality has been made constructively interesting and the fear of it thereby removed that a patient can stand normal excitement. Just as one drink leads invariably to another, so an emotion seems to take the place of the first drink by producing the same mental condition. This emotional contagion is an exceedingly important point. It is the cause of a great deal of unaccounted for alcoholic behavior, behavior which is often the hardest to control.

Why a man under pleasant emotional stimulation seeks narcotic escape from reality in the same manner as he does from unpleasant emotions is an interesting question, but difficult to answer. My own theory is that a neurotic is unconsciously, and possibly consciously, afraid when his emotional equilibrium is disturbed, no matter what the quality of the disturbance may be. When he is in a state of euphoria, he evidently feels the need of a stabilizer to the same extent as he does in dysphoria. Just as he is bored when he looks inward, so he is frightened when he looks outward, if the customary scene has changed even a little.

An individual who was prematurely confident of his self-control fell from grace at a recent football game. "When your team made its first score, you had your first drink", I said. He started to tell me it was not until the half was over, but saw my point before he had finished. "Yes", he said, "I never thought of it that way before, but it is perfectly true. Between the halves that first actual drink went down with as little compunction as if it had been the third or fourth ordinarily. I lost my emotional balance when the team scored and got into the alcoholic frame of mind before I knew it."

XVIII

Much trouble is caused by men trying to force themselves into an uncongenial environment on the plea that they like it when intoxicated. As a matter of fact, they like almost

anything when intoxicated, and nothing when sober. Somewhere in them is a supposedly genuine discrimination. When a natural interest is unearthed or a new one acquired, they find that it is not necessary to enjoy everything, or even many things, if they will soberly and sincerely expend their energy on the few things that catch their imagination and hold their attention. Where there is no real interest and none can be created, the difficulty of the problem is tremendously increased. These obvious truths are mentioned because it seems to be a part of the treatment to drive home platitudes as if they were profundities.

XIX

Moral victories, strange to relate, have to be watched carefully or they turn into defeats. Apparently the resistance of the individual is exhausted by the struggle, and he falls prey to the suggestion absorbed during it, though the provocative situation is over. Often a patient bravely resists the "occasion" itself only to yield a day or two afterwards in a most unexpected manner. If he does not actually give in to the temptation, he is more apt to be depressed than elated in spite of his triumph—that is, of course, temporarily. In the long run these moral victories are not only helpful, they are the stepping-stones to final success.

Last year a man asked my opinion about going to a class reunion. I had misgivings, but I thought he might as well test his resistance, so it was suggested that of course he could go. The results were unfortunate, but interesting. The first two days he drank nothing and was scarcely tempted. The third day, as he expressed it, "I was taken suddenly drunk before lunch almost without realizing that I was doing anything wrong."

XX

What attitude should the family take while the treatment is going on, is a question that is invariably asked. The answer is that friends and relatives should coöperate with the patient in his own way. If he wants to tell of his work, then show an interest in it, but if he keeps it to himself, then let him alone. Avoid all dramatic gestures such as pouring away

the liquor in the house. If it has been his custom in the past, he should continue to offer drinks in moderation to his friends as a means of keeping up his self-esteem, until it is definitely proven that he cannot stand the temptation. The environment should be made as helpful to the patient as is practical, but he need not be spoiled or coddled.

Of course disturbances in the external life that would depress or worry the normal man have in some cases a decisive influence on the alcoholic situation and must always be carefully considered. The environment, however, is not stressed as much as might be expected because many men show a surprising ability to cope with unpleasant conditions while completing the work, and as many others seem incapable of appreciating an admittedly satisfactory external situation.

XXI

How does the work proceed? As may have been gathered from what has been said, very far from smoothly in the beginning, even with the most intelligent and ambitious subject. It is essential to caution those immediately concerned that the friend or relative undergoing treatment will probably slip several times, and that the size of the slip does not matter in point of view of time or quantity of liquor consumed. In fact, if the patient is going to drink at all, he had much better make a thorough job of it. Anything is preferable to a "successful one-night stand" from which he derives the idea that perhaps after all he can drink and get away with it, or at least learn to drink. As long as this idea is in his head, the reëducation is brought to a standstill. I had a patient last year who continued to get intoxicated at least once a week for two months. This exaggerated situation was due to the youthfulness of the subject, and to the fact that he really did not want to stop when he first undertook the work. But the same thing to a less degree is liable to happen to any patient in the beginning, and it does not necessarily mean that the case is hopeless, if the patient evinces a sincere desire to continue the work. This discouraging prognosis must on no account be made to the patient, as he would then be absolutely certain to live up to what was expected of him. Everything must be

done to make him think that his recent indulgence was actually the last one.

In other words, the alcoholic craving is modified gradually rather than stopped instantly. This is depressing to all concerned and particularly to those who have no basis for comparison and thus hoped that a complete conversion would take place on the first interview. However, a man who is willing to make a sincere effort over a sufficient period of time, even though he cannot be called a very strong character, seems to develop resistance to alcoholic temptation by eliminating his tense state of mind and permitting the dissolution of the temptation in other interests. If, however, he is unwilling or unable to help himself, then there is nothing that I can do for him. So it is to the sincere and intelligent, though not necessarily highly educated, individual that I am anxious to give my attention.

A SCALE FOR MEASURING DEVELOPMENTAL AGE *

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IT is a well-recognized fact that intelligence tests do not tell the whole story of an individual's personality. Even after the best psychometric scales have been administered, a great deal remains to be told. Two children may be the same age, have the same I.Q., be in the same grade in school, and be doing equally good work there, and yet they may show startling differences of maturity.

Take, for instance, the case of George and Walter. These two twelve-year-old boys were born within three weeks of each other. They have lived all their lives in the same neighborhood. They are in the same grade in the same school, and both are doing equally good work. They are the same size and both are in good health. Intelligence tests show no significant differences; for although Walter does better than George on the Stanford-Binet, George tests higher on the multimental scale. X-ray photographs were made of the wrists of both boys, and Walter's wrists were found to be only slightly more developed than George's.

Yet in spite of these similarities, there are startling differences in behavior. Walter is much more mature than George. Walter plays with a large group of boys, of whom he is more or less the leader, and his amusements are prevailingly of the active type—baseball, basket ball, and the other standard team games. George is quiet and retiring. He plays habitually with a boy more than a year younger than himself. He seldom

* Based on a paper read at the Fifth Annual Meeting of the American Orthopsychiatric Association, New York, February 25, 1928. The test in question is described in more detail in *The Measurement of Developmental Age*, by Paul Hanly Furfey. Washington: Catholic Education Press, 1927. (The Catholic University of America Educational Research Bulletins, Vol. II, No. 10.) Copies of the test may be obtained from the Catholic Education Press, 1326 Quincy Street, N. E., Washington, D. C.

indulges in athletic sports. Electric trains appeal to him more than baseball.

Evidently Walter is more mature than George, and the sort of maturity involved is not merely chronological age, not merely mental age, nor even physiological age. It is a maturity of personality which shows itself in a changing interest in amusements, a changing reaction toward other persons, and in general in a changing type of personality. It is this type of maturity for which I have ventured to suggest the name *developmental age.*

These facts, of course, have long been obvious to psychologists, and in consequence we have begun to use such terms as *later boyhood, early adolescence, the period of competitive socialization, the questioning age,* and others. By the use of these terms we recognize the fact that the child, as he grows older, changes not merely in intelligence and bodily size, but in his general reaction patterns as well.

The use of these terms to denote the progress of developmental age is far from satisfactory. For one thing, psychologists have notoriously failed to agree on any one classification of the stages of growth. This lack of agreement is evident not merely in the nomenclature of the various stages, but—what is infinitely more serious—in the number and duration of the stages as well.

But even if psychologists should agree on a standard classification for the periods of developmental age, the ideals of modern science would scarcely be satisfied. Modern science demands quantitative methods. It is not enough to classify growth of developmental age into stages. A method of quantitative measurement must be devised. The study of mental growth offers a parallel example. Once psychologists were satisfied with the classification of degrees of intelligence by such terms as *moron, normal, dull, imbecile,* and so forth. But with the development of the test movement, we are no longer dependent on such general and merely descriptive terms. In the intelligence-quotient technique, we have a quantitative and relatively exact method of measurement. Cannot the same thing be accomplished in the case of developmental age? Cannot some method be devised for the quantitative measure-

ment of this variable? The present investigation is an attempt to answer these questions in the affirmative.

Our first attack on the problem was by means of a graphic rating scale of the type developed by Freyd and others.[1] In order to secure higher reliability the following technique was used: The trait *developmental age* was split up into eighteen subtraits which were seen to be closely related to it in a preliminary study of thirty-five boys. The final score in the rating scale was to be the sum of the ratings on these eighteen subtraits, after they had been reduced to standard measures. It was felt that just as an intelligence scale is made up of a large number of elements, all of which enter into the score, so in this rating scale the score would be more reliable if it were made to depend on a considerable number of separate trait ratings. This conjecture was strikingly verified in the event.[2]

Two judges were used to rate a group of seventy-five boys with a mean chronological age of 169.50 months, with a standard deviation of 15.54 months. The following correlations were found:

Trait	*r*	*Trait*	*r*
A	.76	J	.60
B	.59	K	.69
C	.56	L	.71
D	.74	M	.80
E	.62	N	.89
F	.78	O	.82
G	.56	P	.85
H	.54	Q	.67
I	.61	R	.71
	Mean	.69	

The mean correlation (.69) confirms the finding of previous investigators that two judges are not likely to agree so well that their ratings shall correlate higher, on an average, than about .70. But when the ratings of one judge were pooled together and correlated with the pooled ratings of the other, the coefficient was .89. By the Spearman-Brown formula, the predicted reliability of the composite of the ratings of the two judges would be .94.

[1] See "The Graphic Rating Scale", by Max Freyd. *Journal of Educational Psychology*, Vol. 14, pp. 83–102, February, 1923.

[2] See "An Improved Rating Scale Technique", by Paul Hanly Furfey. *Journal of Educational Psychology*, Vol. 17, pp. 45–48, January, 1928.

Although the rating scale was thus made to yield satisfactory results for research purposes, it was felt that to make the measurement of developmental age possible on a large scale, it would be necessary to develop a paper-and-pencil test. This was accordingly done, and it was given to about 500 elementary-school and high-school boys in the city of Washington in May, 1925. A number of papers had to be discarded because of incomplete data, leaving 450 boys, grouped chronologically as follows:

Age	*Number*
9	49
10	48
11	64
12	67
13	69
14	62
15	61
16	30
Total	450

On this group the test was standardized.

The scale consists of four tests. In Test 1 the child had to check the titles that appealed to him in a list of imaginary books; in Test 2, the activities he enjoyed out of a long list; in Test 3, one out of three possible reactions to each of a list of ideas; and in Test 4, the activities he preferred in each of a number of groups of three activities each.

The reliability of the scale was as follows:

Test 1	.49
Test 2	.72
Test 3	.50
Test 4	.35
Test entire	.76

If the final reliability (.76) seems smaller than might be desired, it must be remembered that the test in its present form takes only about fifteen minutes to administer. If the test were lengthened to twice its present length, the predicted reliability would be .84 by the Spearman-Brown formula; and if it were increased to four times its present length, the relia-

bility would be .93, a figure that compares favorably with intelligence tests of similar length.

To determine the validity of the test, two criteria were used—namely, chronological age and the rating scale. The results were as follows:

	Test 1	*Test 2*	*Test 3*	*Test 4*	*Entire test*
Correlation with rating	.29	.56	.26	.34	.56
Correlation with rating corrected for attenuation	.44	.70	.39	.60	.70
Correlation with chronological age	.36	.49	.21	.25	.51
Multiple correlation of rating with the four tests					.59

The highest coefficient is .70, which represents the correlation corrected for attenuation. This seems to imply that the rating scale and the paper-and-pencil tests measure slightly different qualities.

In order to gain some clue as to the causal factors that are responsible for developmental age, a study was made of its correlation with mental age and with certain physical measurements. As a measure of mental age, the Haggerty intelligence examination was used. Weight and standing height were the physical measurements employed. As measures of developmental age, both the results of the rating scale and the test scores were used. The experimental group for which these coefficients were calculated consisted of about sixty-seven boys, all those for whom data were complete. Since the effect of chronological age would be considerable, this variable was partialed out in both instances. The results were as follows:

	Mental age	*Weight*	*Height*
Rating	—.15	.28	.40
Test score	.23	.22	.16
Mean	.04	.25	.28

It will be seen that height and weight give significant correlations in both cases. The coefficient for mental age, however, is negative (—.15) with the rating scale and positive (.23) with the tests. This seems to suggest that the cause of developmental age is something physical, for the average of the two correlations with physical measurements is .26. This means that within a group of boys of a given age, we are more

likely to find the larger boys enjoying the same type of activity than we are to find the brighter boys doing so.[1]

There is no reason to be surprised at this relation of personality changes to physical growth. Recent research has demonstrated the dependence both of certain growth phenomena and of certain personality changes on the presence of particular autacoid substances in the blood stream. Especially at adolescence it is not surprising to find the development of body and of personality keeping pace with each other.[2]

Still another attempt was made to prove the dependence of developmental age on physical factors. The ossification of the carpus is considered a more reliable index of physical development than gross measurements of height and weight because the latter depends not only upon development, but on physical type as well. Accordingly, through the courtesy of Dr. C. C. Caylor of Providence Hospital, Washington, a study was made by means of X-ray photographs of the ossification of the wrist bones of nine pairs of boys. In each of these pairs the boys were of the same chronological age, but one boy of the pair had a very high developmental age, the other a very low one. In five cases out of the nine the boys with the higher developmental age show more advanced carpal ossification as well, in the judgment of Dr. Caylor. The relation, therefore, remains unproved. Yet certain cases are very suggestive of such a relationship.

The importance of developmental age and the part it plays in the make-up of human personality is perhaps best illustrated by a series of cases. Before the cases can be studied, however, it is necessary to establish age norms. Tentative norms were established from a series of sixty cases. The mean score for various ages was first plotted. Then a straight line was fitted to these dots by the method of least squares, and from the equation of the line thus derived the age norms were calculated.

[1] See "Some Preliminary Results on the Nature of Developmental Age", by Paul Hanly Furfey. *School and Society*, Vol. 23, pp. 183–4, February 6, 1926.

[2] How close this relation may be is brought out in the author's *Gang Age* in a graph which shows a close parallelism between a curve representing the ages at which boys lose their interest in Scouting and curves representing the data of various investigators on the oncoming of puberty.

Given a boy's chronological age (C.A.) and his developmental age (D.A.), it is possible to calculate his developmental quotient (D.Q.) by dividing his C.A. by his D.A. and multiplying by 100. Boys with a D.Q. greater than 100 are more mature developmentally than other boys of their age, and the reverse holds true of boys with a D.Q. of less than 100. Three cases are herewith presented—one of high, one of average, and one of low D.Q.

Case 1.—Eugene is not yet fourteen years old. The ossification of his wrist has reached almost adult development. His Stanford I.Q. is 92. He became pubescent at the age of twelve years and nine months. Now he is physically almost an adult.

The maturity of Eugene's personality is scarcely less striking than his physical development. On our test he obtained a D.Q. of 170. He plays habitually with a group of older boys, and their activities are of a rough, vigorous type. They enjoy the standard team games, but particularly football. The group wanders about a good deal from one part of the city to another. They play poker surreptitiously in an abandoned garage and snatch a fearful joy from smoking cigars. It is distinctly a sophisticated gang, which prides itself on being on speaking terms with the local bootleggers.

Case 2.—Thomas, with a D.Q. of 109, is a specimen of what a normal boy of twelve ought to be. He enjoys team games—particularly basket ball. Scouting appeals to him, and he is an enthusiastic member of a troop. He is fond of pets, enjoys roller skating, and shares the twelve-year old's contempt for the gentler sex.

Case 3.—Donald, at fifteen, with a D.Q. of 66, shows no abnormalities on the ordinary psychometric tests. His I.Q. on the Stanford revision is justified by his work at school. A physical examination is quite negative and he is of about average weight and height for his age.

It is only when we begin to study Donald's personality and his adjustment to his group that we begin to detect a type of abnormality not revealed by ordinary tests. The boy is extremely effeminate. He never plays the standard group games—baseball, football, basket ball—with the other boys. He has been stigmatized by his companions as a "sissy" and is somewhat persecuted. The only recreational work that he has shared with his fellows is Scouting, in which he has taken a moderate interest. Until out of grammar school he frequently joined in the childish games of the tiny girls living on his block. He has only one close friend at school, Ralph, whose own D.Q. of 88 shows that he also is well below normal.

Much of the modern progress in the study of childhood has been due to the use of quantitative, instead of merely qualita-

tive, methods. It is felt that the concept of developmental age introduces quantitative methods into a field in which hitherto research has been on a purely descriptive level. Since developmental age is connected with the growth of the whole personality, rather than with a single aspect of it, as in the case of mental age, educational age, or physiological age, this new concept ought perhaps to be useful both to the clinician in his study of particular children and to the research psychologist in his investigation of childhood in general.

THE RURAL COURT AND THE CLINIC

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THE Children's Court of Clinton County, New York, was established in 1922 by the law of the state of New York that made county children's courts compulsory. It is located at Plattsburgh, the county seat, a city with a population of 11,550. The county covers 1,136 square miles and has a population of about 46,000. Its northern boundary is the line between the state of New York and the province of Quebec, Canada. It is largely an agricultural community, the only industries being four paper mills, two shirt factories, and an iron-ore mine and blast furnace. These employ a comparatively small number of people. In the city of Plattsburgh, the chamber of commerce lists 530 wage earners employed in industrial establishments. At the iron-ore mine and blast furnace approximately 560 men are employed. There is also a regular-army infantry post in Plattsburgh. Only 2½ per cent of the population are foreign born.

The court is unique in that it has the only woman judge of a children's court in the state and also the only judge who is not a lawyer. The fact remains, however, as Mr. Lou has said in *Juvenile Courts in the United States*,[1] that although the "court concerns itself with social justice rather than strict justice, it is still a court of law"; all official cases have to come into the court on a sworn petition, and judgments are rendered after formal court hearings as in any other county court. In the seven years of its existence, there has never been an appeal to a higher court. The clerk of the court is a psychiatric social worker who acts also as probation officer. The city attendance officer, a man, also acts as a probation officer, on a part-time basis.

All cases of neglected and delinquent children under six-

[1] *Juvenile Courts in the United States*, by Herbert H. Lou. Chapel Hill: University of North Carolina, 1927. p. 82.

teen years of age come under the jurisdiction of the court. It also has exclusive and original jurisdiction in all cases of non-support in which children are involved, and in all cases of children born out of wedlock, regardless of the age of the mother.

The reason for the existence of the children's court is the protection of the child, and this fact is always kept in mind. Delinquent and neglected children are treated in practically the same manner. An effort is made to convince both the parents and the child that the court is interested only in the welfare of the child. Investigations are made, in so far as possible with the limited staff and facilities available, in accordance with the best principles of social procedure. Disposition is made only after a very thorough study of the child and its environment and all facts pertaining to the case.

Since February, 1927, the court has had the services of a child-guidance clinic sent out by the state department of mental hygiene. The staff consists of a psychiatrist and a psychologist. The clinic is held once a month and spends only half a day in the court, the other half day being devoted to the public school. It is open to the general public, and other agencies are kept informed of the date each month and are encouraged to bring in their problems. At the most only four cases can be examined during the time allotted, and as other agencies avail themselves of the clinic, not all of the time is given over to children's court work. It is interesting to note in this connection that the clinic came into the county and went to work very quietly, with no publicity whatever. It has developed the educational side of its work by contacts with parents and referring agencies, and has apparently demonstrated the application of psychiatry to the social problems of the community. Requests for examinations have been made by the superintendent of the children's home in Plattsburgh, the superintendent of the poor, the city judge, the sheriff of the county, and a lawyer. Recently two physicians have requested that they be notified of the dates of the clinic.

The social-psychiatric history is secured by the clerk of the court, and whenever possible, the parents are brought in for an interview with the psychiatrist. The psychologist

begins the examination with the Stanford revision of the Binet-Simon test, supplemented by the performance and educational tests. The psychiatrist makes the physical and psychiatric examinations. The findings are discussed with the judge and the clerk in analyzing the problem and in making recommendations. In outlining plans for treatment, the facilities and resources in the county for handling the problems must of necessity be considered. The psychiatrist prepares a written report on each case and confers with parents and others in regard to recommendations whenever it is necessary. In some cases children have been brought into subsequent clinics for treatment by the psychiatrist.

Cases are selected to be presented to the clinic because (1) the investigation and study of the child indicates that, although it is of normal intelligence, there is some underlying motive for the delinquency, which has not been discovered; (2) there is a placement problem in which the psychiatrist's recommendation will be helpful; (3) there is a question of mental defect.

Forty-three cases have been referred to the clinic by the court since February, 1927. The table on pages 140–44 presents the legal charge on which the child came into the court, the reason the case was referred to the clinic, the psychiatrist's provisional diagnosis and recommendations, and the final judgment and disposition by the court. There are six cases in which no formal petition was filed. These are cases that were classified in the court as "informal". "Informal" cases are those that are brought in for advice or assistance by parents or others interested in the child, without formal court procedure.

The fact that twenty-five of the forty-three cases were neglected children or informal cases is significant because in a survey of 610 cases of children handled by the court, over 70 per cent were classified as neglected or destitute and less than 30 per cent as delinquent children. This is evidently not the experience of most of the other courts. Statistics from a survey made of juvenile courts in the United States by the Children's Bureau at Washington in 1918[1] show that

[1] *Courts in the United States Hearing Children's Cases; Results of a Questionnaire Study Covering the year 1918*, by Evelina Belden. United States Children's Bureau, Publication 65. Washington: Government Printing Office, 1920.

Court charges	*Age*	*Sex*	*Reason for referring to clinic*	*Provisional clinic diagnosis*	*Recommendations of clinic*	*Judgment and disposition*
Neglected child under improper guardianship	2–6	M	Placement problem	I. Q. 90. Normal	No special recommendation	Later committed to institution as neglected child
Neglected child under improper guardianship	6	M	Placement problem	I. Q. 94. Normal	Boy has good possibilities if given opportunity under proper supervision	Committed to institution as neglected child
Neglected child under improper guardianship	8	F	Placement problem	I. Q. 88. Unstable	Question of home life. She will note anything immoral in home	Committed to institution as neglected child
Neglected child	10	F	Foster-home problem (stealing)	I. Q. 87. Lack of understanding in home	Institution temporarily for discipline and training	Returned to institution
Neglected child under improper guardianship	13	M	Placement problem	I. Q. 55. Mental defective (moron)	Special-class material. Commitment to institution to receive proper training	Committed to orphanage and placed in special class in public school
Neglected child under improper guardianship	15	F	Placement problem	I. Q. 45. Mental defective (imbecile)	Commitment to school for mental defectives	Committed to Rome State School
Delinquent child	11	F	Problem child in institution	I. Q. 74. Border-line defective. Normal reactions of child of long institutional residence	Should have special training, preferably private home	No private home available. Committed to industrial school
Delinquent child	12	F	Stealing	I. Q. 85. Dull normal. Motive for act to purchase presents for others and win praise	Private home where circumstances are understood, if possible; if not, institution preferable to own home	Committed as neglected child to orphanage and given special training in music. Later private home
Delinquent child	15	M	Obscene motions and remarks in school	I. Q. 63. Mental defective (moron)	Return to clinic for treatment	Probation and returned to clinic for treatment
Neglected child	14	M	Placement problem	I. Q. 60. Mental defective (moron)	Will adjust in community. Develop motor ability. Train speech defect	Vocational training secured. Arrangements made for training in speech
Neglected child	8	F	Placement problem	I. Q. 63. Mental defective (moron)	Wassermann test. Commitment to Syracuse State School	Positive Wassermann. Treatment. Commitment to Syracuse State School

Court charges	*Age*	*Sex*	*Reason for referring to clinic*	*Provisional clinic diagnosis*	*Recommendations of clinic*	*Judgment and disposition*
Neglected child	5	F	Placement problem	I. Q. 88. Dull normal	Free home, if Wassermann is negative	Positive Wassermann. Treatment
Neglected child	4	F	Placement problem	I. Q. 87. Dull normal	Wassermann test; if negative, free home	Positive Wassermann. Treatment
No court charge	11	F	Institutional problem. Unwilling to respond to instruction	I. Q. 80. Dull normal	Let her assist with younger child to develop responsibility. Return to clinic	Instructions carried out
Delinquent child	14	F	Placement problem	I. Q. 57. Mental defective (moron)	Commitment to Syracuse State School	Committed to Syracuse State School
Delinquent child	14	F	Placement problem	I. Q. 60. Mental defective (moron)	Commitment to Syracuse State School	Committed to Syracuse State School
No court charge	14	M	Truancy problem	I. Q. 82. Dull normal	Give working papers as soon as possible. Remove from home	Recommendations given to school department
Delinquent child	14	M	Placement problem	I. Q. 69. Mental defective (moron)	Remove from home influences. Work on farm	Committed to State Agricultural and Industrial School
Delinquent child	13	F	Placement problem	I. Q. 75. Border-line defective	Bring into city and place with sympathetic person to continue schooling	Private home not available. Placed in children's home in city
No court charge	14	M	Stealing	I. Q. 112. Superior intelligence	Turn ambitions into social channels	Recommendations given to father
Neglected child	10	F	Placement problem	I. Q. 70. Border-line defective	Leave in regular grade until unable to progress; then special class	Recommendations given to school and to superintendent of children's home
Neglected child	5	F	Placement problem	I. Q. 74. Border-line defective.	Give another psychometric test before going to school. Leave in institution for training. Return to clinic in 6 months	Recommendations to be carried out
No court charge	9	F	Behavior problem in her own home	I. Q. 68. Mental defective (moron)	Under proper care, can adjust to simple vocation in community. Try special class	Special class not available at present. Child supervised by clerk of court
Delinquent child	12	F	Placement problem	I. Q. 72. Border-line defective.	Vocational work will be more valuable than academic. Work with mother to supervise	Indefinite probation
Delinquent child	13	F	Placement problem	I. Q. 74. Border-line defective.	Commitment to Hudson State Training School	Committed to Hudson State Training School

Court charges	*Age*	*Sex*	*Reason for referring to clinic*	*Provisional clinic diagnosis*	*Recommendations of clinic*	*Judgment and disposition*
Neglected child; in institution	5–9	M	Estimate of intelligence and advice as to training desired	I. Q. 110. Super-average intelligence. Ambivert personality. Internal strabismus of left eye	Examination by nose-and-throat specialist and removal of tonsils if necessary. Examination by opthalmalogist and following of his recommendations regarding strabismus. Should enter school in first grade. Foster home, if possible	Recommendations followed as to specialists. Entered school in first grade. Foster home not available at present time
Delinquent child	15	F	Runaway girl in bad company; charged with petty larceny	I. Q. 96. Average intelligence. Delinquency problem; wayward girl	Commit to school where she will have proper training. An attempt should be made to correct her faulty conception of her own responsibility in larceny	Adjudged a delinquent child. Committed to New York State Training School for Girls. Clinic report forwarded to school
Delinquent child	14–8	M	Child has been in court for petty larceny. Advice desired as to social treatment	I. Q. 57. Mental defective (moron). Delinquency	Operation for hernia indicated. Should remain in special class. Strict supervision. If he commits any further delinquent act, commit to state school	Adjudged a delinquent child and placed on probation. Within a week child in court again for stealing and committed to state school. Clinic report forwarded to school
Delinquent child; now on probation	9–7	M	Child plays truant. Advice as to reasons for truancy desired	I. Q. 90. Average intelligence. Reading disability. Behavior problem	Dental care. Special tutoring in reading to overcome disability. If reading disability is corrected, truancy and other delinquencies may cease.	Dental care secured. Change of school made and special attention given to reading. No further delinquencies have occurred in ten months
Delinquent child; now on probation	13–6	M	Poor school work. Child on probation for stealing in company with other boys. Advice as to social treatment desired	I. Q. 60. Mental defective (moron). Vocational problem	Leave in special class. Additional training along mechanical lines. If farm on which he is working is satisfactory, leave him there in home rather than in his own home	Still in special class. Impossible to secure training along mechanical lines now. Farm satisfactory and arrangements made to have him live there
Delinquent child; has been on probation nearly a year	14–6	M	Making no progress in school	I. Q. 66. High-grade moron	Is too old for special class. Should continue in school. Try to develop responsibility by getting him appointed school officer. Try to secure Big Brother for him.	Boy's probation period expired. Recommendations of clinic given to mother and to school. Unable to secure Big Brother for him

Court charges	*Age*	*Sex*	*Reason for referring to clinic*	*Provisional clinic diagnosis*	*Recommendations of clinic*	*Judgment and disposition*
Delinquent child; now on probation	12	M	Gets into petty difficulties. Not interested in school. Plays truant. Advice as to social treatment desired	I. Q. 85. Dull normal. Behavior problem	Dental care. Change of school. Return to clinic for treatment	Dental care secured through school. Change of school made. Returned to clinic three times for treatment. Has not played truant since first clinic visit. Is more interested in school. Behavior is improving
Informal case	15	M	Boy is problem in home. Has stolen property of older brother and sold it for candy. Makes no progress in school	I. Q. 79. Dull normal. Behavior problem	Urine examination to rule out diabetes as physical problem and basis of desire for candy. Regular weekly allowance. Education in social hygiene	Urine examination made by family physician; result negative. Weekly allowance provided. Psychiatrist instructed and gave boy pamphlet on social hygiene. Recommendations of clinic given to brother, who is boy's guardian
Neglected child under improper guardianship	5	M	Placement problem	I. Q. 69. Border-line intelligence (not adoptable)	Should not be placed for adoption, but could be sent to an orphanage. Reëxamination in 1 year	Adjudged a neglected child under improper guardianship. Committed to orphanage. Clinic report sent to orphanage
Neglected child under improper guardianship; now in institution	9–6	M	Disciplinary problem in institution	I. Q. 89. Dull normal. Behavior problem resulting from inferiority complex	Build up confidence in himself. Help him to face jibes of boys of his own age with more stamina. Boarding home, if possible.	Boy became considerably more of problem in institution. No boarding home available. Committed to Children's Village to have benefit of psychiatric department. Clinic report forwarded to Children's Village
Neglected child under improper guardianship; now in institution	12	F	Disciplinary problem in institution	I. Q. 93. Average intelligence. Behavior problem	Reasoning with her in regard to bad habits. Return to clinic for further suggestions and encouragement.	Has returned three times to clinic, but there has been very little improvement in her behavior so far
Neglected child under improper guardianship	15–6	F	Behavior problem. Mother has permitted her to be out with men late at night	I. Q. 79. Average intelligence (dull normal)	Advice to mother in regard to social-hygiene education. Break off friendship with older man. Try to develop responsibility of father toward family	Case continued and family under supervision. Advice in social-hygiene education given mother by psychiatrist. Friendship with older man broken up. Coöperation of neither parent has been secured so far

Court charges	*Age*	*Sex*	*Reason for referring to clinic*	*Provisional clinic diagnosis*	*Recommendations of clinic*	*Judgment and disposition*
Neglected child under improper guardianship; now in foster home	15	F	Making no progress in school	I. Q. 67. Mental defective (high-grade moron with seclusive personality)	Dental care. Tonic to be prescribed by family physician. Special class. More social contacts; Girl Scouts if possible. Education in sex hygiene by clerk of court	Dental care secured through school. Tonic prescribed. No special class available in school. More social contacts made through school, but unable to place in Girl Scouts. Sex-hygiene education accomplished
Neglected child under improper guardianship	14-7	F	Placement problem	I. Q. 88. Average intelligence. Social problem	Dental care. Return to school. Remove from guardianship of parents if possible and place with grandfather. Explain necessity of this move to child	Dental care secured through school. Returned to school. Impossible to prove charges and remove child from guardianship of parents. Case dismissed in court
Neglected child; now in institution	6	F	Placement problem	I. Q. 74. Deferred diagnosis of dull normal	Repeat Wassermann test after provocative dose of sulpharsphenamine. Remove tonsils. Give second psychometric test before entering school. Eliminate question of syphilis before adoption. Train at orphanage and return to clinic in six months	All Wassermann tests negative. Tonsils removed. Not yet returned to clinic
Neglected child	13	M	Placement problem	I. Q. 75. Normal, slightly dull. Reading disability	Should have adequate special tutoring in reading. Leave in special class. Foster home, if possible	Special tutoring in reading secured in school. Left in special class. Foster-home placement
Informal case	16-2	F	Advice desired as to training so girl can support self after decease of mother	I. Q. 51. Low-grade mental defective	Dental care. Training in simple dressmaking and household duties. Exemption from school. Commitment to school for mental defectives may be necessary later	Recommendations given to mother by psychiatrist. Report of clinic sent to superintendent of schools
Neglected child; now in institution	12-9	F	Estimate of intelligence and advice as to training desired	I. Q. 98. Average intelligence	Dental care. Tonsilectomy may be necessary. Careful and tactful supervision to guard against social indiscretions. Foster home, if possible.	Dental care and physical examinations given by institution physician and dentist. Matron advised by psychiatrist with regard to supervision. No foster home available at present time

over 57 per cent of the cases in courts that handle children's cases were delinquency cases. An examination of the statistics kept for the Children's Bureau by twelve courts during the year 1927 shows that 5,746 delinquency cases were reported as compared with 1,289 dependency and neglect cases.[1] It is not unusual, when a child is brought into the court on a petition alleging that he is a delinquent child, to find from the investigation and the evidence given at the hearing that he is a neglected child rather than a delinquent child. In such a case, he is, of course, adjudged a neglected child.

An analysis was made of the forty-three cases in an effort to ascertain the social factors underlying the problem. Although only nineteen of the children were found to be mental defectives, there was a history of mental defect in twenty-three families. In two families there was a history of psychosis. Three children from one family were found to be suffering from congenital syphilis. It was obvious that thirty-six children had never had any kind of adequate home training or supervision. Nineteen children were not provided with adequate school training—that is, the curriculum of the public school was not adapted to them (*i.e.*, special-class material), and there was no other provision in the community for them. Seven children had spent practically all their lives in institutions, six of them in orphanages, and one was born at a state school for mental defectives, where her mother had been a patient, and had lived there for nine years. There was a history of immorality on the part of either one parent or both in twenty-five cases. Fourteen parents had a history of alcoholism. Thirty-two of these children came from broken homes—homes in which the parents were separated or one parent had died. Six children had no homes. These figures are interesting when compared with a survey that was made of 447 families handled by the court, 260 of which were broken homes. Six families were receiving public relief. Nine children were in institutions as public charges. Seven parents had served penitentiary sentences. Five had been arrested

[1] Letter from Gertrude Scott Nutt, in charge of Juvenile Court Statistics of the United States Children's Bureau, March 26, 1928.

for non-support, one father was a bigamist, and one a bootlegger. In one case there was a question about the nationality of the child. This is quite a contrast to home conditions as reported by Miss Lyday in her account of the work of the mobile clinic from the Iowa State Hospital.[1] In the communities visited by that clinic, environmental conditions in the towns and rural districts were found quite satisfactory in most of the cases, and the children were living with their own parents in comfortable homes.

A few of the cases that seem to illustrate fairly typical problems are presented here.

Bernice, a twelve-year-old girl, was brought into the court by the constable of the small town in which she lived. He brought also her suitcase containing her entire wardrobe, stating that he felt sure the judge would send her away. The complaint was that she had stolen money from her teacher on two different occasions. Both parents were dead, and her grandfather, with whom she lived, had asked to have her taken to the court because he refused to keep her any longer. She was placed in the detention home, and the grandfather came into the court the next day to file a petition alleging that she was a delinquent child. Investigation showed that the girl's mother had died about three years before. She was said to be a good woman who took excellent care of her four children while she lived. After her death the father kept the children with him for a while, living with a woman who was known to be immoral. They were in this environment for about a year when the paternal grandfather, a man of some standing in the community, took the children to live with him. The father had died a year before the court experience. The children received excellent physical care in the grandfather's home, but there was no understanding or sympathy with the ordinary desires of youth for pleasure. A fourteen-year-old brother had been sent to an industrial school because of truancy.

The grandfather absolutely refused to take the girl back into his home. In the detention home she was contented and very responsive. She helped cheerfully with household tasks and, although there was plenty of opportunity, made no effort to take things that did not belong to her. The matron reported that she was more helpful and trustworthy than most of the children who had been there. She was examined at the clinic. Her chronological age was 12–0 and her mental age 10–3, I.Q. 85. The diagnosis was "Dull-normal intelligence, delinquency; personality difficulty." The psychiatrist believed that her delinquency had been prompted by a desire to stand well before others, win their approval, and prove that she would not take a dare. The following recommendations were made: "She has sufficient intelligence to have her moral sense aroused and training will do a great deal

[1] *The Place of the Mobile Clinic in a Rural Community*, by June F. Lyday. MENTAL HYGIENE, vol. 12, pp. 77–89, January, 1928.

for her. The problem may be handled from this point of view, by stimulating her ambition to win praise along scholastic lines or in developing any special abilities she may have. A private home, where the circumstances are understood, will be the best place. If this is impossible, an institution is preferable to return to a home where she will not be welcome and where no attempt to understand her will be made.'' A private home was not available at the time and she was committed as a neglected child to an institution whose superintendent is progressive and has a very good understanding of girls. A copy of the clinic report was sent to the superintendent.

The child did not do very well in academic work the first few months, but it was found that she had some musical talent, which was developed, and she seemed to be happy and contented. Since the beginning of the present school year, she has been doing much better school work and is interested. There has been only one recurrence of the stealing and this occurred during the first few days of the child's residence at the institution, when she was left in a room with a purse containing a small sum of money. The superintendent felt that this was the natural reaction of any child to such a temptation under the circumstances. Two months ago she was placed in a private home with a woman who understands the problem, and is getting along very well.

The father of Alan, a fourteen-year-old boy, came into the court to ask for advice. He was a farmer of some standing in the community who was anxious to give his family of four children as many educational advantages as possible. This boy had been sent to Plattsburgh to attend high school. His father paid his room rent, and he worked for his board at a boarding house. He secured his spending money by carrying an early-morning paper route. He felt that a bicycle was a necessity and had been saving his money to purchase one. One of the women in the boarding house worked in an establishment that handled bicycles and had agreed to get him one at wholesale price, when he had sufficient money. He secured the entire sum of money in such a short time that she felt sure he could not have saved it from his earnings and questioned him. He told her that he had formed an alliance with a ''bootlegger'', who had paid him to secure customers for him. He did not know the man's name, his address, nor the license number of his car. He claimed that he met him on the street and gave him the names of prospective customers and was paid at these times. His story was believed and the federal officers were called in to hunt for the ''bootlegger''. The story did not ring true, but the boy stuck to it, adding more details each time he was questioned. The father was advised to bring the boy to the clinic a few days later.

In the meantime the people at the boarding house discovered that some boxes of cigars had been stolen from a garage on the property, which was rented for storage purposes. When the boy was confronted with this fact, he admitted that he had taken the cigars and sold them and that the ''bootlegging'' story was a product of his imagination. The clinic report showed an I.Q. of 112, indicating ''superior intelligence''. The psychiatrist reported that in his opinion the desire for the bicycle had become a ''fixed idea'' and that the irregular methods of obtaining money had been adopted to acquire the bicycle. He felt

that the boy's intelligence and initiative demanded an outlet, which could be found in an ambition to lead in studies and games, and that his sense of loyalty could be turned into social channels such as church, school, boys' organizations, and so forth. This information was given to his father. Nothing more has been heard about the boy, as the father placed him in a school in another part of the county.

Arthur, fourteen years old, was brought into the court by the humane officer as a neglected child. His mother had been dead for several years, and his father, a shiftless farm laborer, had married a sixteen-year-old girl, and had left the boy in a shack on the outskirts of the city to live with a seventeen-year-old brother. He prepared his own meals and at times did not have enough to eat. He was ragged and unkempt. He had a slight speech defect and was sensitive about this. He was committed to the children's home in the city, as a neglected child under improper guardianship. He made a very good adjustment in the home. He became neat, clean, and willing and helpful about the institution. He could do a great deal with his hands, but made no progress in school, remaining in the third grade. Ten months after his admittance to the institution, he was brought into the clinic. His chronological age was 14–9 and his mental age 8–1, I. Q. 60. The diagnosis was "Mental defective, moron group", but the psychiatrist reported that, although mentally subnormal, he would be able to adjust to the community. He recommended that the boy be given training for his speech defect and that his ability in drawing, mechanics, and wood-working be developed. Good academic work could not be expected of him. There is no trade school in Plattsburgh and the only facility for vocational training is the continuation school of the public-school system, but a child is required to complete the sixth grade before he can attend continuation school. An exception has been made, however, in this child's case and arrangements have been made to transfer him from regular class work to special work with the teacher of the continuation school. Here he will be given an opportunity to develop his motor ability. There is no speech-defect clinic available, but an effort is being made to get this training for him from a private teacher.

Louis, aged fourteen, was brought into the court as a delinquent child on the complaint of the father of one of the little girls in the school that the boy attended. He had been making obscene motions before the little girl and also had used obscene language in conversation with other children. Investigation showed that his father was a farmer. The parents were respectable, but lived in a poor neighborhood. They appeared to be a little superior to their neighbors. The boy was in the fifth grade of a rural school and had not been a problem in the school, but on the way to and from school had quarreled a great deal with the other boys. An aunt in a neighboring town was more prosperous and lived in a more wholesome environment than the boy's family and was willing to take the boy into her home and let him go to public school. He was placed on probation, with the understanding that he was to live with his aunt. An examination in the clinic showed an I.Q. of 63; diagnosis: "Mental defective, moron group." The psychiatrist reported that he showed the usual subnormal reactions of lack

of judgment and immaturity. "Physically he is sexually precocious and doubtless the sex urge, in combination with an immature mentality of the moron type, resulted in an exaggerated sex imagery." He recommended that the boy be left in the home of his aunt and that he be returned to subsequent clinics for treatment. This has been done, and the boy has returned for treatment. He has been on probation for eight months and is getting along very nicely in the community. There have been no complaints from the new school.

From these cases it can be seen that the community resources for social treatment are limited. The county, with state aid, employs a county nurse, who does tuberculosis, prenatal, infancy, pre-school, and school work outside the city of Plattsburgh. The humane society is organized for the protection of both children and animals, but it is primarily interested in the prosecution of cases and has no facilities for social case-work. The city of Plattsburgh employs a school nurse, a city nurse, and an attendance officer, who do excellent work. The pastors of the various churches have been most helpful with advice and suggestions, but there are no church clubs or recreational facilities. There are two active Girl Scout troops and two groups of Camp Fire Girls in Plattsburgh. Three Boy Scout troops have been organized during the past two years. The county has but one supervised playground for six weeks during the summer.

The percentage of institutional placements is much larger than it should be, as a result of the fact that the county bills are paid but once a year, and while institutions are willing to wait for their money, individuals are not.

Many of the subnormal children could be cared for in the community if the schools provided adequately for the special education of these children. The fact that out of a group of forty-three there were nineteen children who needed special training which could not be provided in the schools shows the need for more special classes and for vocational training. There is only one special class in the county, and the only vocational work that is done is in the continuation school of the city of Plattsburgh. Pupils are not admitted to the continuation school until they have completed the sixth-grade work. The larger number of these children are not capable of doing sixth-grade work, and therefore have no opportunity

for vocational work before leaving school. An exception has been made in one case, but cannot be made the rule.

The clinic has demonstrated its usefulness to the children's court in a rural community. It has further possibilities, however. If there were more psychiatrists available, so that more than one day out of the month could be devoted to the county, more cases could be referred and more time could be devoted to each case. A psychologist should not be required to do social work. If full-time psychiatric social workers were employed, to follow up the cases that do not need court supervision, the value of the clinic would be greatly increased. It is to be hoped that as the state becomes educated to the value of these clinics, their staffs will be enlarged and they will be able to make a much larger contribution to the work in the rural community.

MENTAL HYGIENE IN THE PUBLIC SCHOOLS*

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ON every hand to-day we hear of the growing responsibility of the school in developing character. Many place faith in schemes for character education. Character codes, courses of study, and panaceas of all kinds are being proposed by individuals, by the press, by organizations, by curriculum makers, and by the great foundations for the promotion of public welfare. But why all of this agitation at the present time? The title of a recent book suggests the answer; it describes the state of our civilization in this age of science and the machine—*Whither Mankind.* This is an age of unrest, and it isn't all merely the result of post-war influences. There is an immense stirring up of thought and an increase of social contacts as a result of the recent developments in transportation and communication. Consequently, modes of living are changing faster than we can adjust our modes of thought. Few will deny that the whole social fabric is being rent in the growing process, that the old safeguards and restraints are proving wholly inadequate to orient boys and girls rationally and harmoniously to life in this age. Parents, teachers, and all others who are concerned over the welfare of youth are looking for assistance; there is tremendous need for wise and sane counsel in the field of public education. Of what value is mental hygiene in a task of such magnitude?

A few years ago we might have ventured this same question in regard to the hygiene of the body, and even to-day there are some who believe that the attention given to health and sanitation in the public schools is not justifiable. But the health programs of the schools do have the support of the majority of the patrons of public education. The lessons learned from the World War have helped to solidify public

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opinion in regard to the health of the body. But let us consider more carefully the problem of mental health in the light of our experience gained in the greatest social upheaval in modern history. The serious nervous disorders of returning soldiers and the important work that has been done in the reëducation of shell-shocked victims of the war have opened our eyes to the possibilities of prevention in the practice of mental hygiene. But is there need in time of peace for guidance in the field of mental health? Should we be concerned in the schools with the problem of a few individuals who should be taken care of in special institutions? The hard-boiled business man pays taxes for the support of special schools and asylums, so why not send these unfortunates where they belong, or—is our problem of wider proportions?

Let us examine some of the more pertinent facts in regard to the general problem of mental health. In 1922, $75,000,000 were expended in caring for patients in hospitals for mental diseases. Several states report that one out of twenty adult deaths is in a hospital for the insane. We are told that there are more patients in such public institutions in this country than students in the colleges and universities. Yet these startling figures do not tell half the story. There is a great social and economic loss from the mild mental disorders that cannot be adequately measured.

What, then, are the implications for us in public education? The keynote of all progressive work in modern medicine, hygiene, and sanitation is prevention. So with mental conflict and maladjustment. Research, in addition, has revealed to us that many of the mental diseases of adulthood are preventable when scientific treatment is applied at an early age. We are told that the psychopath, the neuropath, the criminal, and the delinquent might in many cases have been saved from bitter experiences by the early observance of a few simple, but fundamental principles of mental hygiene. But even among the more normal and responsible people there are many who are the victims of unhealthful associations, morbid fears, superstitions, mental conflicts, unsocial attitudes, inferiority complexes, and all the other types of maladjustment, who could have been helped in those early days by the right kind of training. In the light of these facts we are forced to accept

mental health as a vital aim and cardinal objective in our scheme of democratic public education. Childhood is truly the "golden age of mental hygiene".

What, then, is the program for the achievement of this aim? First of all, the school should supply wide opportunities for self-realization by the pupils, for the first condition of normal mental health is a proper adjustment to one's environment. This, in the language of the school, is the problem of classification. We have ceased to think of children as being alike in capacity, but for a long period education was conceived in terms of mass production and the children as so much raw material to be turned out in model "T" fashion, much in the manner of Mr. Ford's famous product. At certain periods during the day, we manufactured the various parts, each cast in an unvarying mold—a nut here, a bolt there—and if the product proved a failure, we discarded it as unfeelingly as a machine operator discards faulty material that fails to measure up to the standard of the inspector in the assembly plant of modern industry. Only very recently and only in the better educational communities to-day do we find any practical evidence of a changing conception of the ideals of our schools. In these more progressive schools, however, we do find systematic attempts to classify and study the pupils, with a view to providing educational opportunities that will be more in tune with their individual needs and capacities.

Please bear in mind that I do not mean to disparage the work of the old type of school, for here and there in all ages was to be found the master teacher with the understanding heart. Dr. Henry Turner Bailey has given us a picture of such a teacher, imbued with the desire to discover the talents in every scholar. He tells us of a country school in which the boast was made that there were no failures. In visiting this school, he asked the teacher if it were really true that there were no failures in her school. The teacher replied that this was true—that each child was a specialist. He pointed to a little girl in the front row and asked what her specialty was. Very proudly the teacher answered that Mary was the singer. And true enough, little Mary burst into song that charmed her hearers. "And what of this boy?" he then inquired. "Why, Ralph is our artist." Attention was called to an ex-

hibit of his work. "And what of yonder stalwart youth?" said he, pointing to a gangling youth in a far corner. "Herbert is our specialist in height. There is not a molding or a window-pane he cannot reach. Herbert, will you please lower the window?" Whereupon, Herbert unfolded his lanky bulk from his undersized desk and proceeded to lower the window, while every child in the room beamed in appreciation of the boy's superb feats in the manipulation of the upper sash. Here at least was understanding of the problem.

During the last decade many attempts have been made to solve the problem of individual differences by the use of various schemes and teaching devices. In Baltimore and Santa Barbara, differentiated courses of study were provided for the slow, normal, and bright groups. In Detroit, the entering first-graders are divided into three groups, X, Y, and Z. Children in the X group are required to cover the minimum essentials, those in the Y group are required to do more enriched work, while those in the Z group are offered a greatly enriched course of study. The Cambridge, Massachusetts, plan had two parallel courses of study of six and eight years respectively. The bright children were expected to complete the elementary grades in six years, and provision was made for them to transfer from one to the other course at various points along the way. Elizabeth, New Jersey, and many other cities provide several sections to the grade. Batavia, New York, and Newton, Massachusetts, provide a coach teacher for each grade whose duty it is to devote her time to the laggards. Then came the special class or ungraded room, in which those who need special help are given this instruction under a highly trained teacher. And finally there developed the whole battery of special classes in the larger schools where such grouping as the following is possible:

1. The mentally deficient group (I.Q.'s 30–65).
2. The mentally deficient child with special abilities (65–90).
3. The supernormal or gifted child (above 135).
4. The problem child.
5. The child handicapped by physical defects.

If we carried this differentiation to its logical end, we should arrive at some plan of individualized instruction. Very recently, a number of school systems have introduced experimentally this very scheme in order to break the educa-

tional lockstep, so that every pupil may progress at his own rate. The best known are the Burk plan, as worked out in the elementary school of the San Francisco Teachers College, and the Dalton plan, introduced by Miss Helen Parkhurst into the high school of Dalton, Massachusetts. It is interesting to note that this latter plan has had more phenomenal success abroad, for it has been adopted officially in Holland and in Moscow, experimentally in Norway, Germany, Poland, Austria, and Spain, and extensively in England, Japan, China, and India. The Dalton plan breaks up the traditional classroom organization. Each grade room is turned into a laboratory, the teachers become specialists, and the course of study consists of a series of unit assignments to be mastered at the learner's own rate.

In all of these schemes the primary aim is to fit the work of the school to the capacities of the child. Problems of overageness, retardation, and elimination from school, while not entirely solved, are very much simplified, and we have a much more efficient and a better adjusted group of pupils. Thus does the modern school recognize and attempt to solve this first problem in mental hygiene.

The second step in the school problem of mental hygiene, I shall call promoting an understanding of the self. Cameron Beck, personnel director of the New York Stock Exchange, told the teachers of this state, at a recent meeting in Columbia, that the greatest of all qualifications necessary for success in teaching is an understanding heart. What does this mean? It certainly does not mean a maudlin type of sympathy nor does it mean soft pedagogy. I like to feel that Mr. Beck had in mind a more scientific type of understanding, the understanding of the psychologist and the social worker. But this needs some analysis.

We have always known that the most important factor in the learning process is the attitude of the learner. If we can supply the urge, the drive, the purpose to learn, we have the battle half won. On the other hand, if the pupil's mind is set against the task, our hope of success is slight. In either case this attitude, firmly fixed within the neurones, is most difficult to eradicate. We can no more throw off the shackles of attitude than we can throw off the shackles of habit. A story is

told by Major Ian Hay which illustrates the potency of strong mental set. Six British soldiers were incarcerated for several days in a dugout. Finally they were liberated. Two of the imprisoned Tommies were Scotchmen, and, when found, they were heartily discussing theology. Two others were Irishmen; they were fighting. The remaining two were Englishmen, and they were completely disregarding one another, for the very good reason that no one had introduced them.

Nowhere is the importance of attitude or mind set better understood than in the world of business. Millions of dollars are spent annually to create attitudes favorable to various products offered to the public in most alluring form. All forms of propaganda, the press, the stage, and the movies, influence our attitudes toward life. But the important point is not the number or variety of these stimulating agents, but the good or harm that will follow as a result of these adjustments or mind sets. If these attitudes are out of harmony with the environment, the result is a maladjusted individual who is as truly a menace and a center of contagion as one afflicted with any serious form of bodily infection. But good or bad mind sets are inevitable; the task of the school is to see that these attitudes shall be just as fine, just as wholesome, just as hygienic as it is possible to make them. The accomplishment of this is no easy task, and to many of us it seems that we have made no appreciable headway. To achieve this goal the child should live through those experiences that produce right ways of thinking, ideals, convictions, and attitudes that are necessary for the well-rounded development of the normal human being. It is the prime duty of the school so to manipulate the learning situations in the school that these desirable adjustments will result.

To meet this situation, the school, through its activities program, its project teaching, its program of extra-curricular work, is valiantly trying to cope with those forces out of school which are the chief obstacles to real achievement in this phase of our educational problem.

And while the full accomplishment cannot be achieved unless the aims, objectives, and methods of teaching are adapted to this end, yet the most potent factor in the development of these hygienic adjustments is the influence and exam-

ple of the teacher. No school or system of education is stronger than its teachers. In order to be a leader in developing right attitudes and right ideals, our teacher must be first of all a well-adjusted personality herself. She must find joy in living and in teaching. She must bring to her daily tasks a buoyancy, a singleness of purpose, and a consecration far above the present standard. She must be a master of subject matter and of teaching technique, but she must also have the point of view of the mental hygienist. She must know and practice the psychology of childhood. She must realize that the most hopeful opportunity of changing a child's behavior is to be found in her own attitude toward the child. When the ideals of the teacher have been raised to approximate these standards, the second great principle of mental hygiene will have been satisfied.

The third and last step in this program is systematic cooperation. For even with our differentiated opportunities for classification of pupils, with the most expert corps of teachers, there will still be cases that need more scientific treatment. The teacher cannot be expected to become a specialist in the treatment of emotional and mental disorders. After everything has been done to adjust the child to the school environment, to provide opportunities for self-realization, after the school's program of activities has been exhausted in the effort to provide mental satisfactions, we must then seek the help and counsel of the child-guidance clinic. Right at this point is the school's greatest opportunity for coöperation. The teacher must not feel that her responsibility ends with referring the case to the clinic. As a matter of fact, this is where it really begins. Many teachers and some school officials feel that the only course now is to rid the class or the school of this undesirable character. We are all familiar with this attitude. "I have done my best—I have tried everything. There is nothing more that can be done in school with him. It isn't right to have him annoy the whole class. If he thinks he can get away with it, the other children will do the same. You must do something with him." And there is a great deal behind this argument from the standpoint of the teacher with forty-five children in her class. We must be mindful of the rights of the entire group.

And yet the best treatment for many children of this type is a coöperative program, with the clinic suggesting a type of treatment and furnishing the school with a complete history of the case. By assisting the child to make friends, by encouraging participation in school activities, by coördinating the efforts of the home and the school, satisfactory adjustment may be secured. On the other hand, the only recourse may be the special class, with its opportunities for a greater range of activities, school feeding, and physical adjustment.

But, some may inquire, is there any indication by which the teacher may know what types of children are most in need of the guidance of the clinic? This is a difficult question to answer, for the factors that enter into such a study are varied and depend upon the opportunities offered by the school. The types of children most frequently referred, according to Winifred Richmond, are the following:

1. "Those who by reason of mediocre endowment are unable to adjust to the social milieu.
2. "Those who by virtue of broken homes, bad companions, poorly suited school opportunities, and the like, develop abnormal traits and possible delinquencies.
3. "Those who by virtue of constitutional deficiencies are distinctly psychopathic in their traits, who are defective in specific emotional and volitional spheres, decidedly uneven and insecure in the intellectual sphere, and who tend to be untruthful, fanciful, secretive, selfish, and one-sided.
4. "Those pre-psychotics who are unstable in nervous make-up, the stammerers, the sufferers from fears and obsessions, children with 'spells' (when not clearly epileptic), with tendencies to dissociation, to seclusion and introversion, to depression, with paranoid trends, and with homosexual and other perversions.
5. "Those suffering from contributory organic disease, notably epilepsy, glandular dysfunction, and the like.
6. "Otherwise normal, everyday children, with definite mental-hygiene problems to be solved. It is with these last especially that the guidance clinic is able to achieve its most obviously successful work, rescuing such children often from lives of distinct limitation and unhappiness, and starting them on new and higher paths to successful and happy adjustment."

Intelligent coöperation between the school and the child-guidance clinic will do much to restore the normal balance of these serious cases. A most important link in this work is the visiting teacher. In many cases where the social worker is unable to gain an entrée to the home, the visiting teacher

will be able to make the contact and bring about the adjustment that is needed.

There is another agency of inestimable value in our program of coöperation. We know that many of the most serious cases of maladjustment have their inception in the pre-school life of the child. Unfortunate emotional traits are developed in many children before the school age is reached. It is here that the pre-school clinic has its opportunity to develop habits and attitudes that may offset the innate tendencies which are likely to develop. Through its program of education for mothers and the correction of physical handicaps that retard development and lead to serious disorders in later life, the pre-school clinic will render valuable service.

And what of the results? In an age of science we must be able to justify expenditures of money for public education on the basis of dollars and cents, facts and figures. We must furnish concrete evidence of the value of such a program. We must be able to answer the charge of the materialists that we are dealers in "sanctified squandor". Unfortunately, it is a difficult matter to measure results of this type of education by the use of standardized tests. Although McCall claims that everything that exists in quantity can be measured, no one has yet devised satisfactory tests to measure traits of character. As one authority states, "All we can say with definiteness and finality is that whereas many were blind, now they see." There are, however, certain measurable results in terms of the greater holding power of the school, of reduction in over-ageness, and of fewer failures. In our public schools, we have been able, through the application of many of the principles and procedures outlined here, to reduce failure in the grades from an average of 25 per cent in 1911 to an average of 12 per cent in 1928. In 1870, 2.7 per cent of all children of high-school age were attending secondary schools, while in 1915, 17.4 per cent of this population were enrolled in the high schools of our country. We believe that, with a more extensive program of mental hygiene, conditions will continue to improve. Something has been accomplished, but we have merely scratched the surface. This, of course, is mental hygiene in its widest sense. But if a school system is to take its place in rank with those of highly civilized com-

munities, if we are to justify the boast that we are an enlightened commonwealth, we must be willing to provide facilities that will bring about the fullest development of our most valuable resources, the youth of the state.

In conclusion, we have seen that the cost and the extent of mental disorders indicate that mental hygiene is a serious social problem. The overcrowding of institutions for the treatment of mental disease, the increasing volume of crime in which the mentally handicapped are involved, and the rapidly changing social conditions due to the industrial revolution and recent inventions, make it necessary to provide a type of education that will produce a better integrated type of citizen. In meeting this situation, the school should provide better opportunities for self-realization, educational and vocational guidance, physical and mental examinations with remedial follow-up, special training for the handicapped with clinic assistance for those who fail to make the desired progress. Teachers must have better training in better methods. Special training must be provided for dealing with children who need special care and treatment. There must be a better understanding of child psychology. Above all—and this I would make the major objective in our scheme—each individual child must somehow be led to realize his greatest potentialities. This is the program of mental hygiene that the public school should provide in any scheme of progressive education.

C. FLOYD HAVILAND

FRIENDS and associates of Dr. C. Floyd Haviland, Superintendent of the Manhattan State Hospital, Ward's Island, New York City, and member of the Executive Committee of The National Committee for Mental Hygiene, were shocked to learn of his death in Cairo, Egypt, on the morning of January 1. Dr. and Mrs. Haviland left New York on December 3 for a Mediterranean cruise and spent Christmas Day in Jerusalem. Shortly after arriving in Cairo, Dr. Haviland developed influenza pneumonia. He was under the care of several American physicians in the Anglo-American Hospital, where he died.

Dr. C. Floyd Haviland was born on August 15, 1875, in Spencertown, New York, the son of Dr. Norman H. Haviland and the late Mrs. Henrietta Newman Haviland. The family later moved to Fulton, New York, where Dr. Haviland attended the public schools, graduating from the high school in 1893. He received his medical education at the Syracuse Medical School, obtaining his degree in 1896.

In 1897 Dr. Haviland joined the staff of the Manhattan State Hospital and passed through the grades of medical interne, junior physician, and second assistant physician, serving under Dr. William Mabon. In 1910 he was promoted to the position of first assistant physician at the Kings Park State Hospital on Long Island, where he remained until 1915, when he became superintendent of the Connecticut State Hospital at Middletown, Connecticut.

While at Kings Park, in 1914, Dr. Haviland, at the request of The National Committee for Mental Hygiene, made a comprehensive survey of the care of the insane in Pennsylvania. From 1916 to 1921, he was chairman of the Executive Committee of the Connecticut Society for Mental Hygiene, and in 1921 he was president of the Connecticut Conference on Social Work.

On December 19, 1921, Dr. Haviland became medical mem-

ber and chairman of the New York State Hospital Commission, in which position he continued until he resigned on July 1, 1926, to become superintendent of the Manhattan State Hospital. At the end of Dr. Haviland's service as head of the State Hospital Commission, it was remarked that his period of service had covered an epoch in the development of the state system in the care and treatment of the mentally diseased, and in no equal period of time since the passage of the State Care Act in 1890 had so many progressive measures been taken by the commission. In his position as chairman and chief executive of the commission, Dr. Haviland had had two purposes continually in mind: first, the improvement of the state hospitals, so that more patients might recover or improve; second, the prevention of mental diseases, so that fewer patients would need state-hospital treatment. For the accomplishment of the first of these purposes, during his service as a commissioner action was taken toward organizing and developing occupational therapy in all of the state hospitals; a medical survey of the state hospitals was made, the medical services were placed on a more uniform and efficient basis, and diagnostic clinics in several of the state hospitals were organized; a survey of nursing and of the schools of nursing in the state hospitals was made, and steps were taken to strengthen and improve their service and to provide better courses of instruction for both nurses and attendants; as a result of the approval of the bond issue for fifty million dollars for state institutions, a comprehensive building program to remove overcrowding and to provide better facilities for patients was undertaken; two new state hospitals and a veterans' memorial hospital were built, and extensive development was carried on in the institutions previously begun at Marcy and Creedmore; for protection from fire in the state hospitals extensive repairs were made and sprinkler systems and other protective devices were installed in the state hospitals. To accomplish the second of the purposes above mentioned, Dr. Haviland was active in increasing the number of mental clinics conducted by the state hospitals, the number of social workers also was increased, and efforts were made to extend the activities of the hospital clinics to problem children. Dr. Haviland was intensively interested

in bringing about the provision for the erection of the new State Psychiatric Institute and Hospital, in connection with the Medical Center, New York City, and also in the formulation of plans for the erection of a psychiatric hospital to form a part of the medical center of Syracuse University. Dr. Haviland believed that these two institutions represented the crowning achievement of his work on the commission.

In the last few years, while superintendent of the Manhattan State Hospital, Dr. Haviland had continued his energetic activities in, and enthusiastic support of, matters relating to the better care of mental patients and to mental-hygiene problems in the community. He was active not only in The National Committee for Mental Hygiene, but also was a member of the New York State Committee on Mental Hygiene of the State Charities Aid Association and of the New York City Committee on Mental Hygiene. A member and fellow of the American Psychiatric Association since 1899, Dr. Haviland served as secretary-treasurer of that association from 1921 to 1924, was vice-president in 1925, and president in 1926. The interests of that association were always close to his heart, and his activity in it did not cease with his retirement from the presidency, but continued to show itself in subsequent work on the executive committee and on the Committee on Relations with Social Sciences, of which he was a member at the time of his death. He was also President of the New York Society for Clinical Psychiatry and associate editor of *The Modern Hospital.*

Dr. Haviland was elected to membership in the National Committee in 1920 and became a member of the Executive Committee in 1923. He was deeply interested in the social aspects of psychiatry and took an active part in the work of the National Committee. He followed with particular interest the work of the Child Guidance Demonstration Clinics, and upon the organization of the Institute for Child Guidance of New York City by the Commonwealth Fund, was invited to serve as a member of the administrative board. He was much interested also in the training of psychiatrists for extramural work and the training of psychologists and psychiatric social workers, and shortly before leaving on his cruise had taken part in a series of conferences in this field.

His wide and varied interests were further shown in his membership and active participation in the following organizations: the American Association for the Advancement of Science, the American Genetic Association, the Association for Research in Mental and Nervous Diseases, the Eugenics Research Association, the American Pathological Association, the American Social Hygiene Association, the American Neurological Association, the American Eugenics Association, the New York State Occupational Therapy Association, the New York Neurological Society, the New York Psychiatric Society, and the New York Society of Medical Jurisprudence.

Dr. Haviland was at one time clinical assistant in the departments of neurology and psychiatry in the College of Physicians and Surgeons of Columbia University. Since 1927 he had been clinical professor of psychiatry in that school.

To know Floyd Haviland was a delight and a pleasure; to be associated with him in his professional work was a privilege. Always enthusiastic and receptive toward progressive ideas looking toward the welfare, not only of mental patients, but of mankind in general, his enthusiasm was a stimulus to those with whom he worked. Genial and kindly in disposition, he imbued his friends and associates and patients with an optimistic spirit; difficulties did not terrify him, but rather stimulated him to greater and usually successful feats of accomplishment. Indefatigable in work, no task or new activity was too great for him to attempt, and increasing demands upon his time and effort were never met by refusals. He gave his life to his work. Possibly his life would have been longer if he had considered himself more, but those who knew him well realize that to him a longer life with inactivity would have held none of the satisfaction that his all too short active life gave him.

CLARENCE O. CHENEY.

ABSTRACTS

THE SOMATIC BASIS OF THE NEUROSIS. By Paul Schilder, M.D. *The Journal of Nervous and Mental Disease*, 70:502–19, November, 1929.

Schilder starts with the premise that every neurosis must have an organic background, since all psychic life has an organic background. The question then is, What do we know about the bodily changes in the neuroses and how does this knowledge add to an understanding of the neurosis? He takes up first the approach from the organic side, and considers the various theories of bodily changes as the causes of neuroses, such as the theory that they are the result of changes in the vegetative nervous system, or that they are due to endocrine disturbances. Each of these theories he shows to be insufficient as an explanation of the neurosis, since the particular bodily changes in question are absent in many neurotics and present in others who are not neurotic, or other organic changes are present that change the clinical picture.

Approaching the subject from the psychological side, however, he finds that a study of the neurosis and of the psychic problems that it involves does throw light upon the accompanying organic reactions. They are, in his view, the bodily changes characteristic of the emotions and emotional attitudes evoked by certain specific life situations. It is possible that a neurotic is an individual so constituted that these reactions are more easily aroused in him than in the normal person, but there is also the possibility that he is a person who was subjected to the influence of strong emotion in childhood, so that his vasovegetative organs were trained in a wrong direction. Psychology and psychoanalysis have shown that every emotion of the present "reactivates the fitting and adequate infantile emotions, and that every emotion of childhood is in turn related to some process in the vasovegetative system". Succeeding experiences leave their traces also, so that "any present emotion sums up all the emotional influences which the vasovegetative system has undergone since childhood". Psychic problems are thus closely interrelated to the problems of the sympathetic and parasympathetic system. Changes are found in the brain mechanisms of the neurotic, as well as in the vasovegetative system, but they also may be related to the special psychic attitude of the individual. The organism is a unit; one cannot make a distinction between the psychic and the organic. But so far the study

of the psychic life and experiences of the neurotic has led to a deeper understanding of the neurotic make-up than a study of the organic symptoms of the neurosis—has even thrown more light upon these symptoms themselves.

THE RÔLE THAT MENTAL HYGIENE PLAYS IN SCHOOL HYGIENE. By James S. Plant, M.D. *Hospital Social Service*, 20:102–08, August, 1929.

The function of the school, as Dr. Plant sees it, is that of education in the literal sense of the term; in other words, that of *leading out* the child from parental authority into the sphere of social authority. In bringing about this transference of the child's allegiance from the one type of authority to the other, the school depends primarily upon the impartation of a set of facts or body of knowledge. It has, however, three other tools—regimentation, failure, and competition.

The rôle of mental hygiene in the schools can be divided into three phases. In the first, which has been fairly well worked out, attention was concentrated upon individuals who were having difficulty in making the transfer from parental to social authority. The problems encountered here are of four types: (1) the child's inability to grasp the body of facts presented, or the problem of intellectual handicap; (2) the child's failure to meet the rigid demands of regimentation, involving all the various problems of the rebel; (3) the child's inability to adjust to failure, with its accompanying tendency to seek refuge in socially undesirable compensations; and (4) the failure to adjust to competition and the problems of phantasy and daydreaming that are apt to arise from such failure. The first task of mental hygiene was to develop a technique for handling these problems, and this it has largely accomplished.

But this first phase of mental hygiene has been in a way negative. It has been concerned principally with pathology. This may be the reason why the psychiatrist is sometimes inclined to the opinion that there must be no more regimentation, failure, or competition. This view leaves out of account two fundamental facts: (1) that there is a social authority to which the child must adjust himself, an authority that makes inexorable use of regimentation, failure, and competition; and (2) that regimentation, failure, and competition may have a real constructive value in the child's education. The second phase of mental hygiene—the phase upon which it is just entering—is concerned with this constructive aspect. Its interest is directed beyond the particular case to the whole school system, and its aim is to arouse the school from its exclusive preoccupation with the academic curriculum to a realization of the need for a "curriculum for emotional

development", in which regimentation, failure, and competition will be consciously used as measures for adjusting the child to social authority.

The third phase of mental hygiene lies in the future. In it the mental-hygiene clinic will reach out beyond the school system to the great group that lies back of it, the parents, the whole population. Its basis will still be case-work, and case-work with those in difficulty, but its study of the causes of individual unhappiness and failure will be inspired by a wider purpose—that of working with the whole of society in a positive drive for mental health.

A Statistical Review of Occupational Therapy in the New York Civil State Hospitals. By Benjamin Malzberg. *The Psychiatric Quarterly*, 3:413–25, July, 1929.

Occupational therapy was adopted as part of the program of the New York state-hospital system in 1922, and every succeeding year has shown a steady growth in its use. At the close of the fiscal year 1923, there were 5,340 patients in the occupational-therapy departments of the civil state hospitals, or 16.2 out of every 100 patients in the total state-hospital population. At the close of 1928, the number under treatment was 13,045, or 29.3 per 100 of the total population.

Beginning with 1926, more complete records were kept, and it is possible to differentiate patients who received physical training only from those in the occupational classes proper. During the year 1926, the total number treated in these classes was 8,684; during 1927, 9,962; and during 1928, 11,024.

Even when the physical-training patients are included, the females under treatment greatly outnumber the males, and in the occupational classes the proportions are over 2 to 1. A fairer comparison is on the basis of ratio to total population of the same sex. Here the difference is less striking, but still evident. In 1928, for example, 13.7 per cent of the total male population received occupational therapy as contrasted with 24.6 per cent of the female population, indicating a definite tendency to favor females in the selection of patients for this form of treatment.

Marked differences are found between the various hospitals in the degree to which occupational therapy is utilized. In 1928 the rate for the whole state-hospital population was 19.3 per cent, but the rates for the individual hospitals varied from 2.5 per cent at Middletown to 48.4 per cent at Marcy. In one or two hospitals there was a decrease in the rate between 1927 and 1928, but the majority of them show a steady increase.

Of the 11,024 patients who received occupational therapy in 1928, 55.0 per cent was suffering from dementia praecox and 16.8 per cent from manic-depressive psychoses. The remaining 28.2 per cent were distributed pretty evenly among the other psychoses, the largest groups being those of general paralysis, involution melancholia, and psychosis with mental deficiency. Comparing the rates per 100 of the same group in the state-hospital population during 1928, we find a relatively high rate for manic-depressive psychosis (27.1), involution melancholia (26.0), dementia praecox (20.2), and psychoses with other brain or nervous diseases (34.3), and a low rate for senile psychosis (9.8), cerebral arteriosclerosis (10.2), alcoholic psychosis (10.9), paranoia (12.3), and general paralysis (14.4). A comparison of the rates for 1928 with those for the two preceding years shows again a general increase from year to year.

The value of occupational therapy, however, must be measured not by increase in the number of patients, but by the results of the treatment. In 1926, 2.0 per cent of the patients under treatment were reported as "recovered"; in 1927, 2.2 per cent; and in 1928, 2.4 per cent. The percentages of "improved" patients reported for the three years were, respectively, 47.5, 49.0, and 46.3, and the percentages of "unimproved" 46.9, 46.1, and 49.0. Deaths amounted to 1.6 per cent in 1926, 1.0 per cent in 1927, and 1.4 in 1928. On the whole, therefore, one may say that there was an improvement in the reported condition of about 50 per cent of the patients in the occupational-therapy departments during these three years. Here also we find marked variations from hospital to hospital. In 1928, with an average rate of 48.7 per cent for recovered and improved patients combined, we find the rates for the individual hospitals varying from a maximum of 80.0 per cent, reported by Utica, to a minimum of 20.5 at Hudson River.

While these variations may be partly accounted for by differences in the definition of "improvement", it is more likely that they are due to differences in the type of patient selected for treatment, since the rate of improvement was found to vary with types of psychosis. For example, to take the figures for 1928, a high recovery and improvement rate (70.7 per cent) was found in the group of psychoneurotic and neurotic patients in the occupational-therapy department, and a low rate (32.6 per cent) among the patients with senile psychosis. Comparatively high percentages were found also in the alcoholic group (63.1), the manic-depressive group (60.8), and the groups with psychopathic personality (68.7); and low rates for the patients with cerebral arteriosclerosis (43.6), the dementia-praecox group (43.7), and the epileptic psychoses (41.5).

From the statistical point of view the 50 per cent of improvement reported for occupational-therapy patients would have more significance if it could be compared with the corresponding rate for a control series or for the state-hospital population as a whole.[1] But even without such direct confirmation of its value, the beneficial effects of occupational therapy will not be questioned by those who have seen the marked improvement in the patients that has followed its more general use.

[1] The rate for the state-hospital population is based upon condition at time of discharge and therefore is not comparable to the rate for the occupational-therapy group, which includes not only patients discharged during the course of the year, but also those in the occupational-therapy departments at the end of the year.

BOOK REVIEWS

A Social Interpretation of Education. By Joseph K. Hart. New York: Henry Holt and Company, 1929. 458 p.

A story is told of a well-known professor of education to the effect that he was once asked to deliver three lectures on an important educational problem. These three lectures proved so helpful that he was requested to supplement his course with a series of some fifteen addresses. Whereupon the professor repeated in fifteen lectures what he had previously said so well and so compactly in three!

Joseph K. Hart is not the educator referred to in our tale, but were he, *A Social Interpretation of Education* would serve very well the purposes of the fifteen lectures. He has written a keen and searching critique of education, but in so doing he has used some 432 pages of text to say what might have been better and more forcibly stated in half or two-thirds that space.

The result is unfortunate. In producing a book which one reviewer describes as being "without particular order, sequence, or plan", he tends to discourage many readers who would otherwise find therein an educational discussion worthy of most serious consideration. For the ideas in the book are significant and the point of view most suggestive. The main outlines of the argument are as follows:

"Education began, and begins, before school." The school, while not the whole of education, should concern itself with the basic functions of the integration and the orientation of the individual. Where organized properly, the child's environment leads to "an outlook, a point of view, a sense of mastery, skill in the circumstances of life and action". Education, thus conceived, concerns the whole child, and relates to the integration of the total personality. In this connection Hart stresses what Dewey has previously emphasized—namely, the social origin of what commonly passes as an individual trait or acquisition. Over and over again he reiterates that "it is the world as a whole—or some community as a world—that rounds out personality and compels upon the individual an integration that corresponds to its own integration; an integrated community will, by and large, turn out integrated individuals—*whole* personalities. A distracted community will turn out distracted individuals."

He then proceeds to show that in the transition from rural conditions and an agricultural economy to a dominantly urban life and

an industrial economy, the educative functions of the community have disintegrated. "The modern community . . . is disorganized. It has no integration. It knows little of neighborliness, or common interest, or community spirit, or aspiration. Its inhabitants are little aware that such a spirit exists."

This situation should, of course, define the problem of the school. But, as Hart shows, the school has failed in just this emergency. In a survey of the history of education (not at all times free from a twisted perspective), Hart shows that the school has been little more than an academic and intellectualistic institution, which has served to compartmentalize life rather than to unify and give direction to it.

Two chapters, *The School in a Century of Drift* and *The Dilemma of the New School*, are in themselves sufficient to justify the publication of the book. In the former Hart shows that the old-time country school was little more than a supplement to the real life activities of children. Life outside this school succeeded in giving direction and meaning to life; "the school was but an incident in that community situation". Its course of study was formal and intellectualistic. "Then, *with the course of study remaining unchanged*, with the same underlying theory of educational processes, and the same methods, that country school was torn loose from such community connections as it had, and brought to the city." And since children of the city "suffer to-day a lack of convincing contacts with those natural and social realities which give experience its feel of reality and which result in habits that make and mold the world", the results are disastrous. "Our schools have become hives of bookish activity from which most children escape as quickly as possible, taking with them few permanent interests, not even intellectualistic ones."

This is, of course, an overstatement, but true enough to receive emphasis. Equally discerning is Hart's analysis of the "new school". He sees the new school as a reaction against the formal and intellectualistic education of conventional schools. It seeks to vitalize education by contact with realities; hence its emphasis upon arts and crafts, dancing, dramatics, mechanics, science, and so forth. Moreover, in its emphasis upon the development of creative minds, originality, initiative, spontaneity, it contrasts with the regimentation in behavior and thought of the conventional public school. But, asks Hart pertinently, "where and how shall the progressive school find the community backgrounds that can give its work social reality—a community that will provide children for the school, that will support the work of the school even when that work is understood . . . ?" And again, "This is the logic of these new progressive schools: crea-

tive social movements need creative education if they are to survive; and creative schools must have the support of creative social groups if they are to mean anything new."

Hart goes on to point out a fatal weakness in the so-called creative education. He sees the advocates of creativeness talking of the creative impulse "as if that could be a private function". They conceive that the school "exists fundamentally as a means of defending the individual child from any control by the past of the human race". "The New School people", he states, "assume that the social order is made up of *individuals;* that these individuals have been badly educated by our academic schools in that they have been habituated to things as they are, until all of their creative mind has been submerged; but that if an education can be developed that will lead these individuals out into a life of their own, free from all the contaminations and repressions of the past, these freed individuals will, in their own good time, create their own social order, or make a world expressive of their own free natures. In this way the hopes of the race will be fulfilled, and education will make us free."

In practice, however, Hart finds that the new schools do not follow the logic of their own position. They talk of encouraging the "creative impulse", but they carefully restrict creativeness to the elementary-school years. After the age of eleven children wish to direct their creativeness toward the solution of problems in the real world and "parents of twelve-year-olds begin to suspect there is more to 'creativeness' than they anticipated in the days when their five-year-olds were 'creating' pretty songs and poems".

Thus, in his discussion both of the traditional school and of the new school, Hart leads his readers to sense the wider implications of education. He points out that education is adequately provided only when the child draws sustenance from a unified community, one that functions dynamically in the lives of its members. Over and over again he emphasizes the point that the problem of education is one with the making of a community, and the making of a community depends upon adults as well as children. Hence Hart is inclined to believe that major considerations should now be directed to the problems of adult education. As Plato looked to the philosopher to organize the ideal community, so Hart seems to pin his hope upon "educational statesmen who can see that the real problem of education to-day is not better schools, but better communities; and who would be interested primarily . . . in the development, in a broadly social sense, of every local community in America, and of schools as agencies of intelligence in all local communities".

The author succeeds in winning our allegiance to a new conception

of the school, or, as he puts it, to "a new doctrine of the school", but as to how this new doctrine is to be incorporated in practice, he tells us little.

V. T. THAYER.

Ethical Culture Schools, New York City.

INTELLIGENT LIVING. By Austen Fox Riggs, M.D. With an Introduction by Frederick Tilney, M.D. Garden City, New York: Doubleday, Doran, and Company, 1929. 230 p.

Dr. Riggs, from his vast experience with the problems of human adjustment, always gives us something constructive in his writings. As Dr. Tilney very truly states in his introduction to the present volume, "Dr. Riggs is not merely one of the outstanding pioneers in an important field of thought and endeavor. He also is the leading teacher of those principles which govern the balanced life." No more fitting tribute could be paid the great work Dr. Riggs has done at Stockbridge.

In this book we have spread before us much of the author's wide experience and the results of the thoughtful consideration that he has given to the important problems of human adjustment. While much of his work has been with adults, his chapter on children is one of the most valuable in the book; a little more consideration of the psychological factors in childhood development would have made it one of the best contributions to child guidance that we have. The chapter devoted to the problem of the unmarried is an able handling of an old subject, dealing simply and convincingly with the question of the adequate adjustment of unmarried people. It has long needed to be written, and we are grateful to the author for having made his exposition so thoroughly practical. In the chapter on training and education, we find so much valuable material that we wish the author had gone a step further and told us at just what age children's curiosity regarding some of the developmental problems of life should be satisfied. We wonder also whether if we established hours during which our children could ask "why", as suggested by Dr. Riggs, it wouldn't take away from the spontaneity that we like to see in children. Dr. Riggs is very rightly opposed to too much supervision of playtime, and to be consistent should not expect to supervise too strictly the intellectual curiosity of children. But in this chapter again we have a splendid statement of some of the essential facts that educators are seeking.

The reviewer found it difficult to wade through the chapter on marriage. There are a number of places throughout the book where the sentences are long and rather involved, and the reader's attention is taxed in following their intricacies. In this chapter on marriage,

especially, this criticism applies. Moreover, the exposition of marriage as a specialized type of friendship proves hardly convincing and at times not altogether logical. If the author of this valuable book were not quite so resistant to some of the teachings of the analytical schools of psychology, I cannot but believe that the interpretation of some of the problems of human adjustment that he discusses might be better developed and better elucidated. Some of the students of analytical psychology will criticize the book rather severely, especially in the matter of the rather meager rôle given to the unconscious as a modifier of mental mechanisms. At times such criticism is definitely pertinent. Dr. Riggs is such a master of the anatomical, biological, and physiological bases of behavior that we can only wish that he might include in his therapeutic armamentarium more of the psychological determinants now generally accepted.

Other chapters are *Human Relations, Wrong Adjustment, Friendship,* and *The Balanced Life.* This last gives the reader an idea of the broad approach to "intelligent living" that the author presents. It unfolds a philosophy of life from the point of view of the psychiatrist in an optimistic and constructive way.

For the lay public the book will prove a very valuable guide, philosopher, and friend in many practical difficulties, for it is filled with common-sense guide posts, which, if followed, should lead us all to a saner and a safer life.

ARTHUR H. RUGGLES.

Butler Hospital.

BUILDING CHARACTER. Proceeding of the Mid-West Conference on Parent Education, February, 1928, held under the auspices of the Chicago Association for Child Study and Parent Education. Chicago: The University of Chicago Press, 1928. 345 p.

The conference whose proceedings are published in this paper-bound volume brought together many of the leading psychiatrists, psychologists, and educators of the country. The record of its papers and discussions is a distinct contribution to the whole child-guidance movement.

In the 67 pages of the section entitled *The Scientific Attitude Toward Character Development,* we find significant papers by Dr. Mark A. May and Professor Joseph Jastrow. Under the heading, *The Emotional Health of the Child,* we have Doctor Bernard Glueck's paper, *The Significance of Parental Attitudes for the Destiny of the Individual,* and Doctor William Healy's *The Constructive Values of Conflicts, Successes, and Failures.* Both of these are written by past masters of their subject and furnish the reader with much valuable information. This section includes also a most stimulating address by the chairman, a distinguished educator, Dr. Max Mason,

formerly President of the University of Chicago. In reading it, one cannot but recognize how closely the points of view of the educator and the psychiatrist have been brought together. Dr. George A. Dorsey, author of *Why We Behave Like Human Beings,* contributes a paper—*How to Make or Break the Child*—which in itself should earn a place for this little volume in the library of every parent and every teacher.

The section devoted to Round-Table discussions takes up the subjects: *Creative Expression and Character Development; The Use of Leisure Time for Character Development; Social Attitudes and Character; Religion and Character; Building Character Through Unified Education.* While some of these discussions do not add much to the sum total of our existing knowledge, and are, perhaps, a bit vague, most of them are unusually frank and illuminating and will open up to educators many creative approaches to their problems. That great social worker, Miss Jane Addams, is most helpful in her discussion of social attitudes and character, and Dr. Solomon B. Freehof's paper, *The Ebb and Flow of Religious Feeling in Adolescence,* presents a point of view on this problem that should be incorporated in every school of religious education. Dr. A. Eustace Haydon also, under the title *The Modern Child and the Idea of God,* gives a most constructive presentation of child psychology and religious psychology.

There are reduplications in the book, as there must almost necessarily be in the proceedings of a conference for which much of the material is prepared without reference to what other speakers will discuss. But, by and large, the repetition only serves to emphasize valuable material. There are points at which the discussion has not been well thought out and is largely platitudinous, but such places are few. In the main, the volume deserves something better than a paper cover, for in it one can learn from many of the masters of child psychology how to approach vital matters of personal development, and while there is a vast amount of literature on this particular subject, there are many more pretentious books that contain much less that is worth while and constructive.

ARTHUR H. RUGGLES.

Butler Hospital.

THE HYGIENE OF INSTRUCTION. By Lawrence A. Averill. Boston: Houghton Mifflin Company, 1928. 386 p.

This book, which deals with the application of mental-hygiene principles to the various aspects of the child's school life, should be read by every one in the teaching profession. It discusses the mental hygiene of attitude and performance, the mental hygiene of the school day and of the different subjects, and wholesome methods of dealing

with the mentally deficient, the gifted, and behavior problems. There are also chapters on the physical basis of mental health, habit and the conditioned reflex, mental conflicts arising out of family situations, and the rôle of the child-guidance clinic in relation to the school. It may be stated at the outset that the book is a comprehensive piece of work and that its quality is consistently excellent.

Each chapter is written in a thoroughly competent fashion. For instance, in the chapter called *Home Sources of Conflict*, we find data as to the frequency with which problems of adjustment arise out of family life, and descriptions of the ways in which the family relationships affect the child. The relation between childhood maladjustments and such factors as parental disharmony, inconsistent discipline, oversolicitude, prolonged dependency, and favoritism, is explained and illustrated. The projection of the parents' own emotional problems into the life of the child, with the disastrous results that often follow therefrom, is not neglected. The other chapters contain equally significant material. One of the especially good features of the book is its constructive point of view; the suggestions that are advanced are in no way visionary. The problems of the teacher are kept clearly in view and the demands made upon her are not unreasonable. The teacher has no excuse for rejecting the book on the ground that it is impracticable.

To be sure, if the suggestions offered in these chapters were all to be applied, we should have a pretty thoroughly reconstructed educational régime. But neither the more progressive educators nor workers in the field of mental hygiene would hesitate to give hearty approval to such reconstruction. Indeed, both groups should unite in stimulating a wide reading of Dr. Averill's book and an application of its contents.

PHYLLIS BLANCHARD.

Philadelphia Child Guidance Clinic.

THE PSYCHOLOGY OF PERSONALITY; AN ANALYSIS OF COMMON EMOTIONAL DISORDERS. By English Bagby. New York: Henry Holt and Company, 1928. 236 p.

This book, whose author is an associate professor of psychiatry in the University of North Carolina, presents much psychological material with a bearing on human behavior. Numerous case illustrations add to its value, even though in many instances we might wish for greater detail of case material. As might be expected, many of the chapters deal with the physiological and psychological bases of emotional reactions. A bibliography at the end of the book gives us a fear sample of the literature on the psychology of personality.

The reviewer is a bit at a loss as to just how wide a reading the book will have or should have. Students of psychology certainly will find it interesting and helpful. Many laymen will be thrilled by the author's explanation of the inferiority complex and its influence on personality. But the student of child-guidance procedure, the educator, or the widely read parent will hardly derive much deep or lasting benefit even from a thorough reading of the volume.

The exposition of the inferiority complex contains much good, sound material; indeed, this part of Professor Bagby's work is so good that one cannot help but wish that he appeared more thoroughly conversant with the more modern views of Professor Freud and some of his younger pupils of the Vienna school. The chapter on worry is also very well done. It explains the mechanisms involved, gives helpful suggestions as to correction, and is accurate both in its premises and in its deductions.

In the chapter on the treatment of inferiority complexes, we have an example of the need of more careful personality studies before conclusions can be drawn. The author makes the statement: "Of three men who became violently insane in the course of one university year, all were transfer students and it could be shown that each of them had been unable to find friends. In this we have an exact parallel for typical prison psychoses." Most students of mental hyigene would have thought that we had progressed beyond the use of the term "violent insanity" in our nomenclature. And the reason for the mental disorders of the students in question was undoubtedly to be found in personality difficulties that kept them from forming friendships, so that the lack of friendship was a secondary rather than a primary cause of their mental troubles. This illustration may seem far-fetched, but to the reviewer's mind it indicates the need of deeper study of personality factors before diagnoses are made. In the chapter on hysterical traits, hardly adequate emphasis is placed upon the unconscious mechanism of hysterical states.

Yet, after all, one has rather to strain after adverse criticism of the book, which on the whole represents one of the very best attempts of the psychologist to deal with clinical material and to present it to the lay reader. When we have extended the opportunities of the child-guidance clinic to the psychologist a bit more freely than has yet been done, I feel sure that the greater use of clinical material, carefully worked up, will be of great value to him, just as I am also sure that the psychiatrist and the psychiatric social worker will benefit materially from a broader fundamental knowledge of psychological principles.

ARTHUR H. RUGGLES.

Butler Hospital.

MARRIAGE LAWS AND DECISIONS IN THE UNITED STATES. By Geoffrey May. New York: Russell Sage Foundation, 1929. 477 p.

MARRIAGE AND THE STATE. Based upon Field Studies of the Present-Day Administration of Marriage Laws in the United States. By Mary E. Richmond and Fred S. Hall. New York: Russell Sage Foundation, 1929. 395 p.

These are companion books, published simultaneously. The first is a digest of the laws and decisions of the various states of the Union, including the District of Columbia, with the purpose of defining the legal requirements for the making of a marriage contract. These laws and decisions are grouped according to the following classifications: (1) the marriage license; (2) solemnization; (3) the marriage record; (4) other requisites; (5) state supervision; (6) interstate relations; and (7) sex offenses and marriage.

After a brief interpretation of the common-law marriage, of the marriage contract, and of the classification chosen by the author, the laws and decisions in each state are given, followed by a list of citations.

The second book, *Marriage and the State,* is a study of present-day administration in the United States of the laws that regulate the marriage contract. Massachusetts, Illinois, New York, Alabama, Wisconsin, California, and Oklahoma are, for specific reasons, chosen for particular study, but the investigation is not confined to these states. A painstaking effort is made to get at the facts and to give an accurate statement of the actual workings of our legal regulations of marriage. The first chapter of the book contains a summary of the history of marriage procedure in this country. In Part I, four chapters treat of "what happens in license offices". Part II discusses some social aspects of marriage, in chapters entitled *Youthful and Child Marriages, Hasty Marriages, Clandestine Marriages,* and *Evasive Out-of-State Marriages.* Part III deals with the marriage ceremony, and Part IV with supervision and enforcement, with a final chapter that offers a set of recommendations and a program of action. An impressive table in the index compares the marriage requirements of the several states.

These books are indispensable to any one who has a serious interest in any aspect of American family life. *Marriage and the State* abundantly reveals that there is not only official and legislative laxity with reference to the entering upon marriage, but even exploitation. Although the indictment of our present practices is severe, the book is always reasonably constructive in its emphasis. The authors are not emotional reformers, but clear-thinking investigators who would discourage crusading for quick and spectacular changes. The well-matured judgment behind the book appears in its advocacy of the

abolition of common-law marriage and the substitution of documentary evidences of the candidates' fitness for marriage in place of publicity by the announcing of the banns.

These books give testimony to the interest, understanding, and confidence of Miss Richmond as in her last years she contemplated the present stress of the American family in its efforts to adjust to modern life.

ERNEST R. GROVES.

University of North Carolina.

BORN THAT WAY. By Johnson O'Connor. Baltimore: Williams and Wilkins Company, 1928. 323 p.

This book presents the interesting work on selective tests for employment conducted by Mr. O'Connor and his staff over a period of several years. The spirit of the clever and challenging title also characterizes the chapter headings, which are as follows: *Human Engineering, Personality, Limitations in Adult Education, Early Training, The Future of Man, Genius, Formulating Knowledge, Opinion and Prejudice,* and *The Dangers of Human Engineering.*

These headings constitute rather dazzling dress for an account of research findings in employment procedures in an industrial organization. The work of Mr. O'Connor and his staff is excellent. We need more of it. His book, however, seems to embellish and dramatize it too much. The superstructure is a bit heavy for the foundation.

What Mr. O'Connor has found is clear evidence of striking individual differences in the ability of applicants and employees to perform certain carefully standardized tasks. He prefers to call these tasks "worksamples" rather than tests. The term has some advantages, but it is doubtful whether they are sufficient to make its use general in employment work. The discussion deals chiefly with the following five tests, or worksamples: (1) clerical aptitude (number checking and word checking); (2) mechanical aptitude (the "Wiggly Blocks" test); (3) finger dexterity (a peg-board test); (4) tweezer dexterity (peg-board test in which pegs are inserted with small tweezers); (5) group contact or personality (use of the Kent-Rosanoff free-association test for determining introversion or extroversion). Proper procedures have been followed in determining the reliability and validity of these tests. The account and the author's deductions are interestingly written, which is a point in favor of the book, if the reader is on his guard not to swallow the deductions whole.

There are three valuable appendices in the book. Appendix A shows the occupations, or types of work, in which individuals who make certain scores on the tests, or batteries of the tests, have the best chance of succeeding. The reviewer knows of no other book

in which proper vocational counseling on the basis of test results has been so carefully worked out. Appendix B gives detailed descriptions of the apparatus, the administration, and the scoring of the individual tests. Appendix C consists of frequency tables, giving the free-association replies of 2,000 individuals to the 100 stimulus words in the Kent-Rosanoff free-association test. One column gives the number of individuals, among the 1,000 men and women measured by Drs. Kent and Rosanoff, who gave each response to the stimulus word. The next column shows the number of times each response occurred in Mr. O'Connor's testing of 1,000 adult men, largely from industry. The final column contains the percentage of individuals who made each answer, based on the total 2,000 tested.

Mr. O'Connor's work is a highly valuable contribution and the reviewer's only criticism is as to the extent of the implications drawn from it. We know too little as yet about the specificity of aptitudes and their determiners in the chromosomes to warrant some of Mr. O'Connor's statements. Hence, his book is well read in conjunction with the recent book on aptitude testing by Dr. Clark L. Hull.

PAUL S. ACHILLES.

The Psychological Corporation, New York City.

INCENTIVES TO STUDY; A SURVEY OF STUDENT OPINION. By Albert Beecher Crawford. New Haven: Yale University Press, 1929. 194 p.

This book is the report of a personnel survey of the students at Yale University, with an analysis of results in regard to certain factors that influence academic achievement. Data were obtained by means of an elaborate questionnaire, designed for the study of the "educational value of purposive motivation and the need for greater emphasis thereon in educational procedure", which was circulated among the students.

The author assumes that there are four variable factors in the academic success of college students—ability, external circumstances, incentive, and experience. In regard to the first of these, ability (as measured by the Anderson tests), it was found that "the factor of initial ability appears to be perhaps even more important in respect to academic achievement than is generally recognized—that students at Yale differ widely in respect to academic ability as measured by mental tests, and that the variations in test ratings are positively related to classroom grades. There is a low negative correlation between mental ratings and reported time spent in study and a surprising lack of any apparent relationship between time of study and grades."

Under "external circumstances", the author deals with economic

status and family background. Economic status includes family income, student's expenses, and degree of self-support. These are treated separately and then grouped under the heading "economic status". The evidence was that "economic advantage is by no means positively related to academic achievement, and, in fact, that the relationship which might be expected from the term advantage is actually reversed". It was found, after equating the various groups in respect to potential ability, that "the tendency of the wealthier students to make lower classroom grades appears to be a function of some other factor than that of difference in initial ability". This is in agreement with the conclusion of a previous work of the author to the effect that students who are working their way through college are more highly motivated than those who are not; and (especially if they are not overburdened economically) that both their better scholastic records and their higher correlation of academic work with mental rating reflects this superior degree of motivation.

The treatment of the second of the "external circumstances"—family background—seems unfortunately inadequate, as under this topic the author considers nothing but the occupation and college training of the parents. He concludes that "sons of doctors, lawyers, ministers, and teachers tend to stand somewhat higher in their college studies than do sons of business men, even after equalizing the contrasted groups in respect both to mental-test ratings and economic status. Sons of parents who are college graduates do not tend to make subsantially better records than do those whose parents did not go to college."

Some interesting and surprising conclusions are given in the chapter on the influence of occupational purpose on the students' academic grades. As would be expected, it is found that there is a striking tendency for the most definitely orientated students to excel in scholarship; but that "(a) family occupation or tradition, (b) knowledge of a definite position awaiting student after graduation, and (c) attainment of unhampered choice of an occuption, all fail to give evidence of exerting any effect upon academic records of Yale graduates". To any one who has done work with students and their personal problems, the importance of "family tradition" and "the attainment of unhampered choice of an occupation" would seem to be important disturbing factors and as such would be expected to affect scholastic accomplishment to a marked degree. It is doubtful, however, whether any conflict arising over the choice of an occupation would be uncovered by the questionnaire method.

The remainder of the study is occupied with a discussion of the failure of the curriculum purposively to motivate the student. The author makes a strong plea for the study and rearrangement of the

curriculum to the end that it may capitalize intellectually the student's major interest with that flexibility needful for adaptation to individual aims and needs.

The book commands the reader's respect for its use of the statistical method. In its later part it will be of interest to educators who are concerned with the perennial question—curriculum specialization versus generalization. To the psychologist and the psychiatrist, the book will be somewhat of a disappointment, as the factors considered, with the exception of that of mental ability, seem relatively unimportant as compared with the influence of personality traits and emotional problems that are not even considered. The book deals adequately with some of the conditions that are related to academic achievement, but can hardly be called an analysis of the most important factors that determine the attitude of students toward study. In this sense the title is misleading.

E. M. DE BERRY.

University of Minnesota.

YOUTH IN A WORLD OF MEN; THE CHILD, THE PARENT, AND THE TEACHER. By Marietta Johnson. New York: John Day Company, 1929. 305 p.

It is indeed true that youth is surrounded by the adult. In the very furniture and physical equipment of the home in which he lives, in his school life, even in his toys and recreations, the child is surfeited with the adult. It is probable that this will always be true; therefore the need of a clearer understanding of the problems of childhood and adolescence. It is only through such understanding that children will be equipped to meet the responsibilities that adult life will place upon them.

The author of the volume under review has pointed to many common errors in the discipline of the average home and has offered a few concrete suggestions of a remedial nature. Her emphasis on the need of play for children is certainly to be commended. Play is the businees of the child. It is in his play life that he learns to know others as well as himself. It is his laboratory of personal experience. Creative work is also of great value for the child. This, though emphasied by modern educators, is still too often ignored by parents.

The author's division of discipline into mental discipline and discipline of behavior is likely to be confusing to many parents and to leave the impression that all conflict and responsibility are harmful to the child. The prolongation of childhood that the author suggests is admirable, but at the same time the complexities of our

modern world and the demands that the environment now makes of the individual render it necessary for the growing child to learn that each step in growth means an increase of individual responsibility. Conflict, the very essence of life, cannot be avoided, and this, too, the child must recognize.

The author points out certain fallacies in the educational system. A great many of these have already been recognized, and some changes at least have been initiated. Efforts are being made to provide teachers with a better understanding of the social, emotional, and physical needs of children, as well as with a more efficient technique in the selection and presentation of subject matter. Many educators will disagree with the author as to the wisdom of postponing the teaching of reading and mathematics until the child is nine or ten years of age. Her idea is that the child may become too dependent on books and lose the power of thinking for himself, but this need not necessarily follow if he is allowed expression and encouraged to think. She suggests and, in fact, stresses folk dancing as of benefit to the growing child as well as the adolescent. This art has its place, but in the reviewer's experience, the average adolescent child is not particularly interested in it as a method of social expression.

There are two highlights in the book that should recommend it above all else—the chapters *Religion and the Child* and *What About Sex?* These chapters cover in a truly admirable way two of the most difficult phases of child training—phases that more often that any others prove to be pitfalls for even the most "advanced" parents. From the standpoint of mental hygiene, careful consideration by parents of the suggestions in these two chapters alone would do much to bring about a happier, healthier childhood and a more perfect adjustment to adult life.

E. S. Rademacher.

Yale University.

Outlines in Health Education for Women. By Gertrude Bilhuber and Idabelle Post. New York: A. S. Barnes and Company, 1927. 192 p.

The authors of this book are, respectively, associate professor and instructor in physical education for women at Purdue University. Dr. Bilhuber's degree is in public health, and she has evidently equipped herself well to teach individual health also. Together the authors have produced a book that will undoubtedly find wide use among teachers of health and among leaders of health-study classes.

There are thirty-two chapters in the book. Thirty-one of them

contain each a full and orderly outline for the study of an important aspect of health, a list of questions to be used in discussion, and a list of references to the literature on the subject. Chapter 32 is called *The College Freshman at the End of the College Year*, and consists of a questionnaire for "stock taking", and a series of term topics with suggestions for their development.

The authors seem to have been able almost wholly to avoid the ambiguity and misrepresentation that so often accompany the brevity of the outline form. There is hardly an instance in which it is not quite clear what the authors meant. Furthermore there is hardly an instance in which most hygienists would not agree that the points made were the points that should have been made.

The great value of such outlines as these lies in the fact that the student who uses them must do considerable reading. The outlines are not tabloid doses of information, to be memorized, but the skeleton of a large subject, which must be clothed in a living body of knowledge. They should stimulate good teaching and good study.

The book anticipates the time—already overdue—when hygiene teachers will be scientifically equipped for their task as specialists in their field; when courses in hygiene will in all schools be as seriously undertaken as they already are in some; and when sufficient time will be allotted to the subject to permit modern methods of education to be used.

FLORENCE L. MEREDITH.

Boston.

THE CONTROL OF THE MIND: A HANDBOOK OF APPLIED PSYCHOLOGY FOR THE ORDINARY MAN. By Robert A. Thouless. New York: George A. Doran Company, 1928. 211 p.

This is a simply written guide to the attainment of what the author calls mental efficiency. He admits that it is usually the poorly adjusted person who seeks such guides and he recommends special care for such people. Nevertheless, he feels that the ordinary man can profit by self-discipline. He criticizes the popular methods for their lack of objective and he is explicit as to what he means by mental efficiency: "to be able to think accurately, to remember what is important, and to forget what is trivial, to feel such emotions as will lead us to useful activities, and to shut out those which are merely painful or useless, etc.".

His own system leans heavily upon the concepts of will power and of auto-suggestion. He warns against the use of such formulæ to cure disease, and he is cautious in his claims for success. He recommends platitudinous comforts, such as remembering that a hundred

years hence the present difficulty will seem unimportant. Concentration, dreams, the inferiority complex, and religion are dealt with in much the same vein. He seems to overlook entirely the desirability of analyzing causes before proceeding to the solution of a problem. To be sure, he announces that his book is for the ordinary man, but he assumes a complete ignorance and unsophistication on the part of his readers. One can at least say for the book that, while it contributes nothing new, it is apt to be harmless.

LESLIE E. LUEHRS.

Family Welfare Clinic, New York City.

DEANS AND ADVISERS OF WOMEN AND GIRLS. By Anna E. Pierce. New York: Professional and Technical Press, 1928. 636 p.

This book is written primarily for deans and advisers of girls, but it should have much value for those who are considering the possibility of entering the field of counseling. It is based upon the experience of one who has for many years been studying methods and procedure in a number of universities and colleges for women.

The book is divided into two parts. The first gives the fields of work that are essential in colleges and secondary schools. Such topics as the following are discussed: social activities, chaperonage, athletics, vocational guidance, student housing, student government, and health. Under this last heading, the author outlines very minutely a program for a student health service that will include both preventive and follow-up work and that will take into account individual differences. Part II presents the dean's personal relations to the position. It indicates the necessary qualifications for a dean and the dean's relationship to the student body as well as to the community. Special emphasis is placed upon the work of the dean of the secondary school.

Appendices include health schedules, record forms, lists of occupations open for women, a description of the modern-type residence hall, and other material that will be found useful in making work with students more constructive. There is also a bibliography at the end of the book in addition to the reference books cited in connection with some of the subjects discussed.

The book offers many suggestions for procedure and suggests plans that can be adapted to various types of schools. It should furnish practical aid to those who are new in this field and act as a stimulus to those who have been for a longer period in close contact with young people.

MABELLE B. BLAKE.

Smith College.

PHYSICAL MEASURES OF GROWTH AND NUTRITION. By Raymond Franzen. (School Health Research Monographs Number II.) New York: American Child Health Association, 1929. 138 p.

This study represents "an effort to derive measures in the general field of growth, development, and nutrition". "The measures here presented are argued for wholly as research devices." A vast number of tables and statistical data are presented, dealing with such matters as weight, muscle size, subcutaneous fat, the symmetry of growth, sex differences, and such specific points as "determination of the residuals for arm girth, calf girth, and biceps subcutaneous tissue".

The first chapter deals with medical judgments of nutritional status. One of the conclusions is that "agreement between ratings of nutritional status made by physicians is too small to endorse this form of measurement". Another is that "the composite of twelve objectified measures agrees more closely with the ratings of any physician than this physician agrees with his colleagues".

Research such as this, if carried on long enough in the same scientific spirit and manner, will serve not only to educate those laymen who are at present content to weigh a child and pass upon its nutrition, but will also be of great value to physicians who at present are inclined to make their diagnoses on far less scientific bases in this field than in any other.

FLORENCE L. MEREDITH.

Boston.

PRESCRIBING OCCUPATIONAL THERAPY. By William Rush Dunton, Jr., M.D. Springfield, Ill.: Charles C. Thomas, 1928. 142 p.

"The book", the author states in his foreword, "has been written with the hope that it will prove informative and of value to the physician, so that he may make use of this treatment"—a most laudable purpose, approached from the vantage point of years of experience in the practice and development of occupational therapy. The author's interest in promoting the use of this treatment has brought him constantly into contact with every phase of occupational therapy. A keen observer, he has carefully collected principles and methods that have been found of value by others, and presents them in this volume.

The book is divided into two parts. Part 1 considers general principles in three chapter—*Significance, Prescription,* and *Fatigue.* The first of these discusses the service that occupational therapy may perform, and sets forth the general principles that should determine the selection of activities: "Individual study of the patient

and a well considered prescription are necessary in order to obtain successful results from this form of treatment."

Chapter 2 takes up the subject of the prescription and summarizes what should be considered before it is written: (1) the object to be attained; (2) the type of occupation; (3) contraindications influencing choice of occupation; and (4) precautions. The prescription should give the occupational therapist a maximum of information in brief form, so that he or she may carry out the treatment intelligently to the end desired by the physician.

The chapter on fatigue is timely, as, in prescribing and administering occupational therapy, both physician and therapist should be informed of the patient's tolerance. The experienced therapist is always on the alert for signs of fatigue and is interested in methods of preventing it.

Part 2 of the book—*Special Application*—discusses the application of occupational therapy in the various fields—mental disorders; general-medical, surgical, orthopedic, cardiac, and tuberculous cases; children; and bed patients. In each of these several distinct fields, occupational therapy has proven invaluable because of its flexibility and adaptability.

In this part of the book the author presents, briefly, yet concisely, the contributions of many recognized authorities toward an understanding of the patient. It is this understanding that makes possible the prescription and its administration. The author wisely balances this material with many concrete examples of the application of occupational therapy, his data representing not only his own experience, but that of many others who have successfully administered this treatment. It is in this emphasis upon a correlation of understanding the patient, prescribing the occupation, and intelligently filling and administering the prescription that the real contribution of the book lies. The therapist needs not only the prescription, but also that intelligent insight into the problems of the patient which guides the physician in formulating the prescription. The physician has the equipment with which to build up this understanding of the patient, but in the formulation of the prescription he must take into account also the varied equipment that occupational therapy has to offer. Unless both the physician and the therapist can thus think through each individual case, the most desirable results cannot be obtained.

The book should be read by every physician and occupational therapist.

Louis J. Haas.

Bloomingdale Hospital.

THE BATTLE OF BEHAVIORISM; AN EXPOSITION AND AN EXPOSURE. By John B. Watson and William McDougall. New York: W. W. Norton and Company, 1929. 96 p.

This is the first publication in book form of the debate between Watson and McDougall on the fundamentals of psychology which took place before the Psychological Club of Washington, in 1924. Under the title *The Modern Note in Psychology,* Watson sketches the main outlines of Behaviorism, which McDougall then attacks, pointing out its inadequacies as an explanation of some of the most common of human experiences, and extending his criticism to include the whole mechanistic hypothesis on which Behaviorism rests. Both as the assailant and as the last speaker, McDougall has much the stronger position strategically, to which devout Behaviorists will probably attribute the undeniable fact that the honors of the argument are with him. The debate makes no new contribution to the theories of either of the two men.

MARGARET H. WAGENHALS.

The National Committee for Mental Hygiene.

MEN AND MACHINES. By Stuart Chase. New York: The Macmillan Company, 1929. 354 p.

One lays down this book almost with a feeling of apology toward machines. Mr. Chase has succeeded in investing them with a sort of majestic pathos, as monsters whose blind faithfulness to the will of their masters has somehow been betrayed. His aim in the book is to investigate the charge that machines have been a curse to man rather than a blessing, and he goes about it thoroughly. He examines the anatomy and functions of the various types of machine, glances at the mechanical devices of the ancient, traces the history of the machine age from Mr. Watt to Mr. Televox, and considers from every possible angle the effects that machines have had and may have upon human life. In one nightmare chapter he describes the next war; for he believes that there will have to be one more war, one swift holocaust, before the dull imaginations of statesmen can grasp what war with modern weapons means. Finally he draws up a balance sheet—on one side the good effects of machines, on the other the evil—and concludes that as the account stands now, the evil outweighs the good, but that in practically every case the evil is due, not to anything inherent in the machine, but to the use that is made of it. In short, as Mr. Chase puts it, it is not the machine that has failed man, but man that has failed the machine.

The keynote of the book is its emphasis upon the necessity for

intelligent control. Mr. Chase might be surprised to learn that he has written an argument for mental hygiene, but that in effect is what he has done. He has shown that the "billion wild horses" that man's brain has called into being are dangerous, not in themselves, but because they have multiplied a billionfold the power for harm of those instincts and impulses in man's own nature of which he has as yet so little understanding and control. The blind forces that he has let loose in the world are in alliance with the blind forces in himself, and both are running wild, to what end no one can say. The only thing certain is that intelligence will succeed in bringing the first under control only in so far as it succeeds in controlling the second.

There is of course the possibility that a creature with the biological equipment of a warm-blooded animal is incapable of living in accordance with the dictates of reason. In that case the very overdevelopment of the cerebrum that has enabled man to raise himself above his brother animals may in the end be his undoing, as the great size of the dinosaurs was the cause alike of their rise to dominance and of their downfall. The brain may go on evolving ever more powerful instruments to be placed at the service of the passions, until some such situation arises as that envisaged by the authors of *Wings Over Europe*, in which one infantile, unbalanced individual holds in his hands an engine capable of bringing in an instant to nothing all the glory and beauty of the world, all the hopes and dreams of man, all the effort and agony that have lifted him out of the primeval slime to what he is. And if this madman of the future should succeed in his purpose—if no merciful bullet should intervene as it does in the play—old Mother Nature, watching the dust slowly settle, would murmur, "Well, that's that", and set to work with a patient sigh on a new experiment with some other form of life, in her long search for a lord of creation who will be lord also of his own destiny through mastery of the forces in his own nature.

MARGARET H. WAGENHALS.

The National Committee for Mental Hygiene.

A STUDENT'S DICTIONARY OF PSYCHOLOGICAL TERMS. By Horace B. English. Yellow Springs, Ohio: The Antioch Press, 1929. 82 p.

Professor English has filled a long-felt need in offering to the student a careful, up-to-date dictionary of terms current in psychopathology and in all branches of psychology, descriptive, experimental, comparative, genetic, and Gestalt. It is concise, and more important than that, it is accurate and shows careful evaluation in that controversial points of view are briefly set down. No undue amount of

space is devoted to the consideration of controversial points such as "consciousness", "instinct", and the like.

Terms have been selected for treatment that, according to the author, are most likely to trouble the general reader or the student, that lend themselves to brief treatment, that increase the book's usefulness for reference. Neurological terms have been omitted, since the author had no intention of compiling a lexicon of every word in various fields that might have a psychological component. A necessarily arbitrary selection of terms from biology, anthropology, and philosophy has been included. It is to be hoped that a revised edition will include more from these fields.

The most complete treatment and the greatest amount of space have been devoted to a discussion of terms current in the general, experimental, and comparative psychology of the university. This is as it should be, since the book is intended primarily for the college student.

Another evidence of care is the fact that the various mental-disease entities appear under the official classification adopted by the American Psychiatric Association. There are also included many, if not all, of the terms to be found in the language of psychoanalysis, whether it be spoken according to Freud, Jung, or Rank, or in the language of individual psychology according to Adler.

This is a booklet that not only the student, but also the psychologist and the psychiatrist in the clinic will welcome. It covers a broad field, and its sharply concise treatment of a variety of concepts awakes in the reader the desire to read extensively of ideas that aroused only the most casual interest before he turned to Professor English's dictionary for help. Its brevity will recommend it to every student in this field of science, for it is a dictionary and not an encyclopedia.

GRACE E. O'BRIEN.

New York City Committee on Mental Hygiene.

RACE AND POPULATION PROBLEMS. By Hannibal Gerald Duncan. (Social Science Series.) New York: Longmans, Green, and Company, 1929. 424 p.

In this comprehensive textbook the author has brought together in an attractive form the ideas, opinions, and theories of various students of population and a great array of facts derived from statistical and other investigations. His aim has been to acquaint his readers with the varied views of scholars in this field without "injecting his own conclusions". The book may, therefore, be likened to a beautiful patchwork quilt, the patches of which have been carefully culled from fabrics of many lands and have been fitted together to form a harmonious whole.

The volume is divided into two books, the first dealing with the problems of races, the second with the problem of numbers. Book I has three parts which treat, in order, the rise and spread of the human group, biology and racial problems, and movements of population and the diffusion of culture.

Interesting chapters related to mental hygiene deal with heredity and eugenics and inferiority and superiority. The heredity factor in mental disease is mentioned, but no light is thrown on the subject. The inheritance of mental defect, however, is more adequately dealt with. The discussion of heredity and environment is summed up in the following significant quotation from Jennings: "The characters of the adult are no more present in the germ cells than is an automobile in the metallic ores out of which it is ultimately manufactured. To get the complete, normally-acting organism, the proper materials are essential; but equally essential is it that they should interact properly with each other and with other things. And the way they interact and what they produce depend on the conditions."

The status of the various races with reference to civilization, culture, and innate ability is summarized from the writings of many scholars. Apparently the author does not share the views of those who believe that the salvation of the world depends on the domination of the Nordic race. Mental tests are held, by most of the writers quoted, to show differences in racial scores, but not in inherent intelligence.

In discussing fecundity and fertility and the control of population by positive methods, the author again summarizes the views of many observers and investigators. The weight of the evidence presented seems to favor limitation of offspring as a means of improving the race and of preventing inadequacy of food supply.

The book is highly to be commended to the reader who wishes to obtain a condensed view of population problems and to the student who wishes to pursue the broader aspects of the subject.

HORATIO M. POLLOCK.

New York State Department of Mental Hygiene.

LAURA BRIDGMAN; THE STORY OF AN OPENED DOOR. By Laura E. Richards. New York: D. Appleton and Company, 1928. 155 p.

This is a charming and readable story of one who was blind, deaf, dumb, without sense of smell, and almost without sense of taste, but who, in spite of these almost insurmountable handicaps, was, through the efforts of Dr. Howe and the devotion of her teachers, put into communication with the outer world.

Dr. Howe's daughter, Mrs. Richards, describes with deep feeling and fine literary expression her father's great achievement, which not only released Laura's spirit from the bondage of darkness, but has had a widespread influence on the treatment of the blind deaf since that time.

Among the incidents that stand out most clearly in Laura's career are the moment, eagerly awaited, when she grasped the idea of the names of objects and the possibility of exchanging ideas with those around her; the touching scene of her recognition of her mother; the fitting of her doll with a green ribbon such as the pupils of the institute wore across the eyes; the celebrations at the institute in which she took a leading part, to her own delight.

It is particularly interesting to read of Dr. Howe's efforts to keep from her ideas of death and of religious dogma. "As I can see no necessary connection between moral and religious life and the intellectual perception of a particular truth, or belief in a particular creed, I see not why I should anticipate what seems to me the course of nature in developing the mental powers."

Unfortunately, during the Howes' absence in Europe, an overzealous teacher introduced Laura to Calvinism, with disastrous results. But great credit must be given to her devoted teachers for her ultimate attainment of a normal maturity and her satisfactory adjustment to life, with warm friends who respected her for her own sterling character.

SAMUEL P. HAYES.

Mt. Holyoke College.

NOTES AND COMMENTS

Legislative Notes *

NEW LAWS
Index by Subject

Administration and Finance
Pennsylvania, H. 1132, S. 661.

Alien Insane
North Dakota, H. 88.

Commitment
Pennsylvania, H. 1132.

Marriage and Divorce
Oregon, H. 364

Veterans
Pennsylvania, H. 1132.

North Dakota

H. 88, Chap. 3. Provides for the immediate notification of the United States immigration officer when any alien convicted of a felony or adjudged insane is committed to a state or county institution supported in whole or in part by public funds.

Oregon

H. 364, Chap. 413. Makes permanent insanity cause for divorce where the defendant has been adjudged insane at least five years prior to the suit and where it appears to the satisfaction of the court by competent witnesses that the disease is incurable.

Pennsylvania

H. 1132, Chap. 267. Amends the Mental Health Act by providing for the commitment and transfer of "insane, weakminded, or incompetent" veterans to the United States Veterans' Hospital.

S. 661, Chap. 203. Authorizes the department of welfare to determine the legal residence of indigent, insane, feebleminded, and epileptic persons returned to Pennsylvania by the authorities of another state or transferred from one poor district to another by the department, and requires the proper district to pay the costs of care and treatment.

* The designations H. and S. in the discussion below refer to bills presented in the House and the Senate respectively.

NEW BILLS

The following bills have been presented in the United States Congress:

H. 6300. Would provide for the establishment of a laboratory in the Department of the Interior for the study of abnormal classes, with an appropriation of $50,000 for same.

H. 7410. (Same as H. 7570 and S. 2556.) Would establish a hospital for defective delinquents.

H. 7627. Would authorize the President to appoint a board of twenty psychiatrists, at salaries of $25,000 each per annum, to be known as the United States Board of Psychiatrists. The duties of such board shall be:

1. To diagnose and prescribe treatment for all mentally deranged veterans.
2. To make a comprehensive study of mental diseases and treatments for same, with recommendations.
3. To recommend to the Commissioners for the Promotion of Uniformity in Legislation a code of ethics to govern the appearance of alienists as expert witnesses in litigations.
4. To inquire as to methods for the chartering of insurance companies against insanity with a view to drafting a policy of insurance that will provide treatment for the insured who becomes mentally diseased and compensation for his dependents.

The bill carries an appropriation of $5,000,000.

S. 1812. Would authorize the Director of the Census to compile and publish annually statistics relating to inmates of institutions for mentally diseased, defective, dependent, and delinquent classes.

S. 2359. Would convert United States Veterans' Hospital No. 94 at American Lake, Washington, from a neuropsychiatric hospital into a general medical and surgical hospital. The bill carries an appropriation of $500,000 for this purpose.

1930 LEGISLATIVE SESSIONS

The following legislatures are scheduled to meet in regular session during 1930 on the dates given:

Kentucky, January 7
Louisiana, May 12
Massachusetts, January 1
Mississippi, January 7
New Jersey, January 14
New York, January 1

Porto Rico, February 10
Rhode Island, January 7
South Carolina, January 14
Virginia, January 8
U. S. Congress, December 1

Twentieth Anniversary of the National Committee for Mental Hygiene

The Twentieth Annual Meeting of The National Committee for Mental Hygiene was held at the Hotel Biltmore, New York City, on November 14. Addresses on various phases of mental-hygiene work were made by Dr. Frankwood E. Williams, Medical Director of the National Committee; Dr. George K. Pratt, Assistant Medical Director; Dr. George S. Stevenson, Director of the Division on Community Clinics; and Mr. John R. Shillady, Administrative Secretary of the First International Congress on Mental Hygiene. Dr. Williams and Dr. Pratt both emphasized the need for trained social workers and psychiatrists to carry on mental-hygiene work; Dr. Stevenson reviewed briefly the history of the child-guidance and community clinics in the United States; and Mr. Shillady reported on the preparations for the Congress, which is to be held in Washington next May.

At the recommendation of the Committee on Resolutions, a minute was spread upon the records of the meeting in memory of each of the following members of the Committee whose deaths had occurred since the last annual meeting: Mr. Otto T. Bannard, of New York City, who served for twelve years as treasurer of the National Committee; Mr. Charles P. Holland, of Brockton, Massachusetts; Dr. C. Banks McNairy, of Lenoir, North Carolina; Dr. Morton Prince, of Boston; Mr. Winfield Quimby, of Boston; Dr. Frederick C. Shattuck, of Boston; Dr. Samuel E. Smith, of Indianapolis; and Dr. David F. Weeks, of Skillman, New Jersey.

All the officers of the National Committee were reëlected for the coming year. They are: Honorary President, Dr. William H. Welch; President, Dr. Charles P. Emerson; Vice-Presidents, James R. Angell, Rt. Rev. William Lawrence, D.D., Dr. William L. Russell, and Dr. Bernard Sachs; Treasurer, Frederic W. Allen; and Secretary, Clifford W. Beers.

The meeting was followed by a dinner at the Biltmore in honor of the twentieth anniversary of The National Committee for Mental Hygiene, which was founded in 1909. More than 600 guests were present, including psychiatrists, psychologists, educators, and social workers from sixteen states and Canada. Dr. William H. Welch, Director of the Department of the History of Medicine of Johns Hop-

kins University, presided at the dinner. The speakers were Dr. James R. Angell, President of Yale University; Dr. William A. White, Superintendent of St. Elizabeths Hospital, Washington; Dr. Frankwood E. Williams; and Mr. Beers.

Lack of space forbids the publication of the speeches in full, but in view of the historic importance of the occasion, it has been considered desirable to reprint the following summary of them, which appeared in the Anniversary number of the *Mental Hygiene Bulletin:*

"Dr. Welch recalled the interesting circumstances surrounding the origin of the mental-hygiene movement in his opening remarks. 'I think there can be no more impressive demonstration', he stated, 'of the progress which has been made during those twenty years than to contrast the little group of fourteen who met on May 6, 1908, at the home of Anson Phelps Stokes, in New Haven, to establish The Connecticut Society for Mental Hygiene, with the great assembly here to-night, great both in its size and in its quality. I should say that it constitutes an extremely impressive indication of the progress that has been made in this great movement. I think it very dramatic to be able to point to those small beginnings in New Haven, to that little group, only fourteen, assembled on that now recognized historic occasion in the home of Anson Phelps Stokes.

" 'The history of great movements, like that of mental hygiene, is often very obscure. It is often a difficult thing to disentangle all the threads that lead to some great movement. In the tuberculosis movement, it is a rather complicated story before you come to the actual conception of the movement as we recognize it to-day. But the historian will have a very easy task when he inquires into the origin of this movement. It is just one man and one book. I don't know any kindred movement where the story can be told in so few words, so directly. It is one man, Clifford W. Beers, and it is one book, *A Mind That Found Itself*. Other books have been written by those who have gone through mental disturbances, but no book in any way, in my judgment, is comparable to his. It is of interest to psychologists, of interest to psychiatrists, of interest to humanitarians—to all who are interested in great social movements.

" 'We recognize, dangerous as judgments of one's contemporaries may be as to the historical niche which one may occupy, that Clifford Beers's name is imperishable in connection with the launching of this great movement.'

"Speaking in a similar vein, President Angell said: 'May I join with Dr. Welch and all of you in my own personal tribute to Mr. Beers, to whom I have had occasion heretofore publicly to express my sense of obligation. I think it is entirely impossible to overestimate

the courage and the devotion that he has shown in building up this extraordinary movement, with absolutely no limit to the personal sacrifice that he has been willing to make, bringing, as it has, literally to thousands upon thousands of people a fresh courage to face life, a fresh hold on human happiness, and a fresh belief in the essential value of human living. This, I think, is a great achievement.'

"President Angell described the mental-hygiene work that is being done at Yale University to relieve students of mental stress, build up healthy emotional and mental attitudes, and prevent mental and nervous breakdowns.

" 'Yale has had the extraordinary good fortune', President Angell continued, ' to have Dr. Arthur H. Ruggles come to New Haven to launch the undertaking, and he did what for this particular sort of work is so critically important—he introduced it absolutely devoid of any morbidity or of the sentimental features which so easily tend to attach to it. He introduced it also with a thoroughly scientific background and setting so that it not only instantly secured the respect and the support of all Yale's scientific men, but because of the manner in which it was done, it instantly appealed to Yale's student body as a natural, sensible, everyday sort of thing to do, if you wanted to make your student group as strong and as vigorous and as wholesome and happy and contented as human beings can hope to be. It was launched at Yale in a spirit of perfectly normal recognition of the fact that along with other disabilities in life, we do have mental and emotional difficulties. These are to be recognized and dealt with exactly as one would deal with other disabilities and not to be treated as something to be hidden, something to be dealt with in a morbid fashion.'

"Dr. White in his speech referred back to the beginnings of the mental-hygiene movement in terms of the work for the amelioration of conditions among the insane, and spoke in high praise of the man whose genius and personality, he said, were responsible for starting this work for which he was being so signally honored on this occasion. 'For a hundred years', Dr. White said, 'patients had been leaving our public institutions for mental disease with a sense that if they had gotten well, they did not owe it to the way they had been treated. In numerous instances they must have felt outraged at the experiences they looked back upon, at the cruelty, the callousness, the lack of sympathy with which they had been confronted during their confinement.

" 'But it was given to only one man who had had similar experiences', Dr. White declared, 'to have these memories of his treatment strike deep to the very core of his being, and there, instead of rankling

and making him resentful, they took root and grew and produced the fruit which is now the mental-hygiene movement. He had been outraged as these others had been, but by some strange alchemy these outrages did not have the same effect. They stirred him to creative activity. They stimulated him to try to find the reason for it all, to try to correct what he felt not as personal animosity and antagonism to him, but as ignorance and stupidity, to try to see that those that followed him should be saved such experiences as he had passed through.

" 'This genius—and I use that word advisedly—whose mind among a million saw opportunity where no one else had seen it for a century, that genius I do not need to name in this assembly. But lest there should be some strangers amongst us who have no inkling of the lifetime of sacrifice to this ideal which has brought about the results which I have only just intimated, I shall speak more fully. That genius is Clifford W. Beers.'

"Explaining the aims and objects of the National Committee and pointing out the preventive character of its activities, Dr. White continued: 'The average patient admitted to a state hospital has already been getting mentally ill over a period of years, sometimes throughout a lifetime of thirty or forty years, and it could not be expected that miracles of cure could be worked in this material; so naturally those who were interested in mental hygiene began to ask themselves the questions: When does mental disease begin? What are its earliest manifestations? How can these manifestations be prevented? And how can the prospective patient who is for the time being on the wrong track be gotten back in the right direction? And so over a considerable period of time we see movements designed to answer these questions.

" 'We find psychiatrists at our instance being introduced into the universities, where they make contact with the adolescent youth of the country, and we find those same psychiatrists realizing that the adolescent who is headed for mental disease has been on the wrong path for some considerable time. And so, then, we find the psychiatrist in the schools, the public schools. We find him prominent in the parent-teachers' group. We find him busily engaged in segregating the defective, the backward, and the abnormal child, and advising for them special methods. And then finally we find him engaged with the whole problem of the care and bringing up and education of children, beginning even before school days with the pre-school child and attempting to correct at the very start habits in the early months of childhood.'

"Dr. Welch expressed gratitude to the National Committee's bene-

factors whose timely financial assistance made it possible to carry forward the work. 'I have mentioned only one benefactor, Mr. Henry Phipps', he said, 'as I believe other speakers, especially Mr. Beers, may be inclined to mention others, but I cannot refrain also from calling attention to the great service rendered by the very generous gifts of Mrs. Elizabeth Milbank Anderson, founder of the Milbank Memorial Fund. It was not only the financial aid which she gave, but it was also the personal interest which she took in the movement. She and Mrs. William K. Vanderbilt, Sr., enabled the work to continue after Mr. Phipps's capital fund had been expended. The Rockefeller Foundation, the Commonwealth Fund, the Milbank Fund, have been, of course, our greatest supporters, giving largely for special studies, surveys, and demonstrations.'

" Mr. Beers, the final speaker of the evening, gave brief reminiscences of the Committee's work, touching lightly and in a personal manner upon some of the significant incidents in the progress of this work. He paid a high tribute to the late Dr. Thomas W. Salmon, who was Medical Director of the National Committee for the first ten years, stating that Dr. Salmon laid the scientific basis of the work, without which, he was sure, the movement would have failed. 'He was an extraordinary man', Mr. Beers said, 'and it was a very wonderful thing that we found him.'

"Further reference was made by Dr. Welch to Dr. Salmon as the man who gave shape and direction to the mental-hygiene movement, who grasped clearly its significance and scope, and devised the line of attack. 'One of the great services of The National Committee for Mental Hygiene', said Dr. Welch, 'has unquestionably been that it made a careful survey of the whole problem. Even statisticians quite remote from this particular field have commented upon the unusual quality, in an organization of this kind, of the statistical studies that have been made. That, of course, was the first step, and Dr. Salmon initiated that and carried it out most ably, as has been attested to by his successor and for a time his assistant, Dr. Frankwood E. Williams, who also was interested in that particular direction. Dr. Salmon gave the primary movement and impulse to the scientific aspect of the work, and was largely responsible for gaining the position of leadership which it quickly attained. I think one of the outstanding achievements has been the creation of an organization which is the authoritative voice of the best scientific knowledge that we have to-day in this extremely difficult and perplexing field.'

"Mr. Beers concluded his remarks with a description of the plans and purposes for The American Foundation for Mental Hygiene which, he said, had been formed primarily as a means for securing

the large funds that will be needed in the future to stabilize the work of the National Committee and to insure the permanency and progress of mental-hygiene work, not only by the National Committee and the state societies for mental hygiene, but by other organizations, institutions, and agencies engaged in such work in this country and abroad."

The British Report on Psychoanalysis

In July, 1926, the Annual Representative Meeting of the British Medical Association instigated the appointment by its council of a special committee "to investigate the subject of psychoanalysis and report on the same". The committee was composed of some twenty physicians and surgeons, with a predominance of specialists in nervous and mental disorders. The Freudian school of psychoanalysis was represented by Dr. Ernest Jones and the Jungian school of analytical psychology by Dr. H. Godwin Baynes.

The Committee's report on the results of its investigations has recently been issued by the British Medical Association. After a brief historical survey of the field of psychotherapy in general and a short summary of the methods and theories of psychoanalysis proper—*i.e.*, the Freudian school—as distinguished from those of the various other analytical schools that have developed from it, the report passes on to a consideration of some of the misconceptions that have arisen with regard to psychoanalysis and some of the criticisms that have been made of it. This latter part of the report is given below:

Misconceptions concerning psychoanalysis

In the course of its sittings, certain misconceptions about psychoanalysis have been brought to the notice of the Committee.

There is in the medical and general public a tendency to use the term "psychoanalysis" in a very loose and wide sense. This term can legitimately be applied only to the method evolved by Freud and to the theories derived from the use of this method. A psychoanalyst is, therefore, a person who uses Freud's technique, and any one who does not use this technique should not, whatever other methods he may employ, be called a psychoanalyst. In accordance with this definition and for the purpose of avoiding confusion, the term "psychoanalyst" is properly reserved for members of the International Psychoanalytical Association. This association numbers some four hundred members and meets in congress every second year. The British Psychoanalytical Society is one of the ten national societies of which the International Association is composed. The number of physicians in this country who practice psychoanalysis is small; there are hardly a dozen in the British Isles and all of them reside in London.

Much confusion and misunderstanding relative to psychoanalysis has arisen from a failure to recognize and adopt the definition here indicated. Thus, clearly, criticisms of psychoanalytical theory or practice should

be confined to the teaching and methods of those who are psychoanalysts in the true sense of this term. This is not always so, and the Committee has received a number of reports and statements adverse to psychoanalysis as a form of medical treatment which, on inquiry, have been found to be based upon methods put into operation not by psychoanalysts, but by other practitioners who adopt or accept the name, but lack the qualification.

The following is an authoritative statement on the constitution, methods, and objects of the Psychoanalytical Association, for which the Committee is indebted to a member of that association:

"The criterion for membership of the International Psychoanalytical Association is an adequate knowledge of the subject. What is regarded as adequate depends on whether the candidate proposes or does not propose to practice psychoanalysis, a higher standard being imposed in the former case. Members of the association may be defined as persons who have so dealt with the internal obstacles normally interposed between consciousness and the unconscious as to be able, in the opinion of their fellow members, to appreciate the functioning of unconscious mental processes. Psychoanalysts have been reproached for shutting themselves off from the rest of the medical profession by forming societies of their own, but they merely follow the custom of other special workers: that is, although they freely discuss their work in various other medical societies, they also further it by discussing the more advanced aspects of it with colleagues who have a common basis of understanding and knowledge of the problems concerned.

"The higher standard for admission to membership, applicable to those who propose to engage in practice, depends on the fact that the activity of the internal 'resistances' is apt to be intensified by personal contact with psychoanalytic work; this applies equally to the analyst and the person being analyzed. It is, in the latter case, for instance, invariably more intensified during the first stages of a psychoanalysis, this incidentally explaining the apparent paradox that a person who breaks off analysis during this stage is often in a less favorable position to discuss the subject objectively than he was before. The standard of insight demanded by the association is, therefore, higher with those who propose to carry out psychoanalytic explorations—*e.g.*, for therapeutic purposes—than it is with those whose interest in the subject is, so to speak, an external one—*e.g.*, educationalists, anthropologists, and so on. This is because the former would otherwise expose themselves to the likelihood of their internal resistances being stimulated and mobilized, with correspondingly deleterious effects on their therapeutic work—*i.e.*, on the interests of their patients.

"The degree of insight varies spontaneously among different people (and even at different times among the same people); it can be aided by appropriate measures—*i.e.*, by psychoanalysis. There are two forms of this—auto-analysis and allo-analysis. The former was the only one available in the early days of the work and several of the leading psychoanalysts, including Abraham, Ferenczi, and of course Freud himself, had perforce to be content with it. Experience soon showed, however, that only very exceptional persons could proceed far by means of auto-analysis and that in any event it is inferior as a method to allo-analysis, so the latter is strongly recommended. In the interests of their patients,

future practitioners are expected to equip themselves as far as possible to avoid the dangers otherwise inevitable in analytic work. Curricula have been devised by special training committees in various countries and they include courses of lectures, reading, personal analytic work, and analyses of patients under the direction of experienced psychoanalytical physicians. The training takes at least three years. There are six training centers—in Berlin, Budapest, Frankfort, London, New York, and Vienna; of these the most fully equipped are those in Berlin, London, and Vienna.

"To sum up, there are two objects of the association, to which the two standards of admission correspond. The first is the furthering of knowledge by the usual methods (society discussions, publications, etc.). The second is the safeguarding of the public by providing adequate training of practitioners. Until this educational work is taken over by some other body, full membership of the association is the nearest existing approach to a diploma in the practice of psychoanalysis."

It is sometimes alleged that in individual instances various harmful consequences may, and often do, result from the practice of psychoanalysis. Many of these allegations certainly depend on the misconception already alluded to, for attempts to use the method are sometimes made by practitioners imperfectly equipped for the task. Psychoanalysts state that such uninformed attempts carry certain dangers, and that these dangers are to be averted only by skill in the use of the proper technique.

It is sometimes supposed that psychoanalysis ignores the relationship between mind and body. The truth, on the contrary, is that psychoanalysis is essentially a biological doctrine, for it deals principally with the conflicts and mal-developments of the instincts, and no one has denied that instincts have both physical and mental manifestations. Further advances in neurophysiology may be expected to make it possible to describe in physiological language the phenomena for which at present psychological terms are alone available.

Again, psychoanalysis has been condemned as a materialistic doctrine which leaves out of account the "higher", such as the more spiritual, aspects of man. This verdict is certainly not justified, since Freud postulates a conflict between this side of human nature and the other or more primitive side.

It is sometimes supposed that psychoanalysis is a panacea for all mental disorders. Practitioners experienced in the method make no such claim. On the contrary, they recognize limitations and even contraindications and urge a careful judgment in the selection of cases. The choice of suitable cases depends, not only on the medical diagnosis, important as this is, but even more on certain individual psychological factors in the patient's constitution, and much experience is needed to be able to assess these correctly.

Another suggestion is that psychoanalysis applied as medical treatment may cause insanity in the patient. No proof of this charge has been discovered by the Committee.

In psychotherapeutic methods other than psychoanalysis it is recognized that the personality of the physician is an important factor in determining the success of the treatment. A similar view is sometimes expressed in regard to psychoanalysts; they state, however, that this is

not so, and that similar results would be obtained in any given case by different analysts possessing the same degree of skill.

It is commonly stated that the inordinate expense of psychoanalytic treatment limits its application to an extremely restricted field. The Committee finds, however, that, for the reasons that (1) psychoanalysts are prepared to work for modified fees, (2) their fees are subject to considerable variations, (3) the cost is spread over a lengthy period, and (4) free clinics exist for psychoanalytic treatment, no person need be deterred by financial consideration from obtaining such treatment, provided of course that he lives within traveling distance of a psychoanalyst.

It has been suggested that a description of a psychoanalysis as actually practiced on an individual patient or patients might be presented to the public in the form of a written or other record obtained at the time of the analysis. The Committee, however, has been satisfied that this is impossible since (1) continuous writing by the analyst would disturb the free train of thought necessary both for patient and analyst; (2) the presence of a third person or of a mechanical contrivance, introduced to make the record, would have a similar effect and would interfere with the necessarily confidential relationship that must exist between patient and analyst; and (3) the gestures, changes of facial expression, manners, and hesitations of the patient, which are important elements in the interpretation of the analysis, cannot be reproduced in a written record.

CRITICISMS AND REPLIES

The following criticisms have been advanced against the theory and practice of psychoanalysis. The replies here presented have been furnished by the President of the British Psychoanalytical Society, and the Committee leaves both criticism and replies to the judgment of the reader.

Attitude of Psychoanalysts to Criticism

Criticism.—Many critics complain of an initial difficulty in getting their criticisms listened to by psychoanalysts, and they ascribe this to what they believe to be a peculiar mental attitude on the part of the analysts—an attitude which they hold is itself deserving of criticism. The complaint takes many forms, but the gist of it is that psychoanalysts are willing to listen to friendly criticisms from psychoanalysts, or from persons sympathetic with psychoanalysts, but turn a deaf ear to criticism which is adverse; they are believed to adopt this latter attitude both to critics who are admittedly ignorant of the subject and to those who possess some knowledge and experience of it; and they justify this course on the ground that the critic has not overcome his personal resistances and hence is not in a position to appreciate or criticize fruitfully the data in question. Such an attitude, it is urged, is an unfair one. It discounts criticisms beforehand, removes all common ground for discussion, and allows the analyst to shelter himself behind defenses erected by him on the basis of the theory at issue and of such a kind that no attack or argument can reach him.

Reply.—"The answer to this criticism is a direct rebuttal. The most extensive evidence can be adduced to show objectively that psychoanalysts do not burke criticism and that the situation which produces, in the

minds of the critics, the impression that they do so is susceptible of a different explanation.

"In the first place it is necessary to distinguish between two things that are often confounded under the name of criticism. The first, to which alone this name is appropriate in science, is an objective demonstration that in reaching the conclusion criticized either a fallacy has been overlooked or a disturbing influence neglected, or that the factors present have been wrongly estimated. For such criticism to carry weight it is plain that two pre-suppositions are necessary: (*a*) that the critic understands the meaning of the conclusion he is criticizing, and (*b*) that the criticism is something more than an unsupported assertion. Now critics commonly talk as if a great number of criticisms which fulfil these conditions—let us call them scientific criticisms—exist and are ignored by psychoanalysts. In reality there is a most striking and lamentable paucity of such criticism.

"In its second, and less justifiable use, the word 'criticism' should more properly be called 'uncritical opposition'. This varies in degree from expressions of incredulity thinly veiled under a scientific terminology to violent and often unprintable abuse.

"The actual attitude of psychoanalysts differs widely from the one imputed to them. No one deplores more than they do the paucity of informed criticism supplied by non-analysts, since informed criticism is vital to progress in science. It is this defect that is responsible for the comparative and unfortunate isolation of psychoanalysis from other branches of science, rather than any desire on the part of psychoanalysts to hold themselves secluded from criticism. Indeed their regret at the paucity of informed criticism has had two very visible consequences. First, it has impelled them to make the fullest use of whatever external criticisms do exist, even of those which do not satisfy the necessary presuppositions postulated above. They have taken the trouble to expose the misconceptions and ignorance on which many of such criticisms rest, and they have been untiring in dealing at length, over and again, both verbally and in their writings, with such criticisms as make any pretense to objectivity. It would be impossible to point to any criticism made of psychoanalysis that has not been extensively considered in psychoanalytical literature; and in medical societies concerned with such topics psychoanalysts have certainly devoted more time and energy to meeting criticism than their critics have in advancing it. A second result of the paucity of external criticism may be seen in the vigor of internal criticism, which has been equal to that shown in any other branch of science, and to any one familiar with the proceedings of a psychoanalytical society the idea that it consists of uncritical agreement is grotesque.

"In respect of what I have called uncritical opposition, it is true that an *impasse* is soon reached, for the situation, being barren of content, does not lend itself to much discussion. Opponents of this kind can hardly expect to convert to their incredulity workers who have ample personal experience of the things denied; for instance, to tell a psychoanalyst that the phenomena he is dealing with all day long do not exist leaves him as little impressed as a chemist would be by the argument that oxygen and hydrogen, being invisible, cannot exist. Perhaps it is their helplessness at failing to achieve any result from 'criticism' on these lines that leads such opponents to invent the fiction that psycho-

analysts are afraid of criticism. The reasons why psychoanalysts conclude that opposition of this character is dictated by subjective and largely by unconscious factors are (1) the demonstrable effect of emotion in deflecting the mind and thus leading to endless misconceptions and misunderstandings about psychoanalytical conclusions, and (2) the extensive knowledge of the nature and sources of this attitude when the opportunity is given—*e.g.*, in psychoanalytic work—of investigating it. Psychoanalysts give this explanation of 'uncritical opposition' because they believe it to be true, and not because they have any reason or wish to burke scientific criticism.

"To sum up, the criticism [just discussed] is essentially a complaint that psychoanalysts will not admit that their work is wrong. They do not consider that it is; hence the *impasse*, which further actual investigation alone will penetrate."

Validity of the Psychoanalytical Method

Criticism.—Some critics offer an alternative explanation to the findings reported by psychoanalysts to that offered by the latter. They assert that these findings are derived, either wholly or in part, from the mind of the analyst and had no prior existence in the mind of the patient. This view seems to them to be supported by what they read about symbols in psychoanalytical literature, particularly in relation to the interpretation of dreams, even those recorded in books. The frequency with which the same signification is attached to the same symbols in relation to widely different persons gives the impression of a preconceived interpretation regardless of the particular case—in short, of its being artificial and mechanical and therefore untrustworthy. They further contend that the process of suggestion by which the patient comes to accept various ideas is facilitated by the special relationship subsisting between him and the analyst, and is in the circumstances inevitable, however little it may be intended or desired. Moreover, it is contended that psychoanalysts themselves are subject to suggestions from one another and are, therefore, prone to adopt uniform views.

Reply.—"The crux of the whole matter lies here: have psychoanalysts discovered what is in the unconscious mind or have they invented it? It is a question that can be answered neither by assertion nor by prejudice, but only by investigation. I suggest that future investigators will have to take into account the following considerations:

"(a) *Intellectual.*—The implication, often openly expressed, that the therapeutic success of psychoanalysis is due to the effects of suggestion, is accessible to direct investigation. Many psychoanalysts had years of experience in the use of all forms of suggestion treatment before studying psychoanalysis, and they should, therefore, be in a better position than their critics to contrast the modes in which the two methods operate. The conclusions reached in psychoanalytical work, so far from being preconceived ideas, all came as quite unexpected discoveries, and every one studying the data for the first time experiences the same sense of surprise and, naturally, of incredulity. Moreover, in every individual analysis the analyst is constantly surprised by finding the meaning, associations, and so on, of the material to be quite other than what he might have anticipated. The subsequent course of an analysis makes it abun-

dantly clear which interpretations are correct and which erroneous, and this independently of whether the analyst or patient accepts the interpretation at the time or not. Further, there are innumerable technical and clinical means whereby the truth or falsity of the conclusions can be objectively checked.

"Quite apart from psychoanalytic treatment, however, there are extensive sources of evidence where psychoanalytic conclusions can be tested without any subjective interpretation being possible. If one listens to the utterances of those insane who are entirely uninfluenced by suggestion, or studies the writings of men dead long ago, who also, therefore, could not have been influenced by psychoanalysts, or examines the data to be found in anthropology, in folklore, in superstition, in poetry, in wit, and in other products of the imagination, the same mechanisms, associations, and interpretations that play so large a part in psychoanalysis are objectively to be demonstrated. It would be hard to point to any individual psychoanalytic finding which could not be demonstrated in these other fields where the influence of psychoanalysts can be excluded. This applies with special force to the very interpretations to which most objection has been raised—namely, to those of symbols, for very few indeed of these, if any, are peculiar to psychoanalysis. The criticism that the interpretation of symbols is too constant and preconceived cannot be answered in a word, for it raises technical considerations relating to the psychoanalytic method which would need lengthy exposition and discussion, as well as a number of misconceptions that would have to be removed beforehand. It is plain that such a question can be finally settled only by examination of the evidence.

"(b) *Affective.*—The criticism here in question vastly exaggerates the power of suggestion and misconceives the nature of the emotional personal relationship on which it is based. To investigate the precise nature of this relationship has been one of the main tasks of psychoanalysis, and it has in this way thrown light on the nature of suggestion itself. To answer the criticism adequately, therefore, it would be necessary to enter into a longer exposition than is here possible. For treatment by suggestion to be effective, there has to be on the side of the patient a positive emotional attitude—*i.e.*, one of respect or trust, perhaps even of affection, towards the physician; even then the success proceeds, not from the physician's 'influence', but from the ideas already present in the patient's mind which he has connected with an imaginary conception of the physician. This condition, however, is very rarely present in psychoanalysis, and even then only for a short period. When it is present, it exercises on the course of the analysis a disturbing influence which has to be detected and specially dealt with. On the contrary, the attitudes of mistrust, fear, suspicion, and hostility always dominate the situation, and are commonly expressed with great vehemence. The picture of the docile patient meekly accepting the analyst's explanation is extremely remote from the truth.

"From the analysis of individuals whose fear of 'suggestion' is specially strong analysts have obtained much knowledge about the nature of this fear, as well as of its general character, and they cannot, therefore, avoid the inference that the criticism here expressed is not unconnected with this widespread fear of suggestive influence, which brings

a consequent exaggeration of its danger. The word 'suggestion' is commonly used as a catchword to cover what are really much more complicated processes. The fear of the analyst, or of his supposed influence, can be shown to be based on a fear of certain buried mental processes with which he has become identified; broadly speaking, it replaces fear of the unconscious mind."

Truth of the Psychoanalytic Theory

Criticism.—Some critics assert that no unconscious mental processes do or can exist; if the phenomena described by psychoanalysts occur, they must be neuro-physiological processes without any mental correlation. Other critics, while admitting the existence of an unconscious mind, object to the special description of its contents given by psychoanalysts. The statement of the findings relative to infantile sexuality, particularly the Œdipus complex and castration complex, evokes in them only incredulity and repugnance; they either deny that these findings are ever true or they refuse to accept the psychoanalyst's doctrine of their universal validity, considering that the evidence in favor of this view is insufficient.

Reply.—"That mental processes can exist without the subject being aware of them has been proved in various ways independently of psychoanalysis. To assert that such processes must necessarily be physiological and not mental in nature is to take up a theoretical position which a very limited philosophical training would refute. But, on the practical side, the reply is that there is no conceivable objection to these processes being stated in physiological language if and when a fuller knowledge renders this possible; in the meantime there is only one vocabulary available—namely, the psychological.

"The gravamen of the criticism is doubtless in the second part—namely, the objection to the alleged content of the unconscious mind. These critics are not convinced by the evidence laid before them. Parenthetically, it may be observed that in the majority of instances they have sampled a small selection of this evidence, or of the conclusions put forward, rather than made a study of the evidence as a whole. On the other side, various readers have found the evidence convincing, so that one set or other must have committed an error in judgment. What reply is the psychoanalyst, whose personal experience can leave him in no doubt on the matter, to make to the former set of readers? He may suggest that, if the evidence investigated has been considered to be insufficient, more of it be studied; for it often happens that a conclusion which is rejected at the first hearing has later to be accepted through the sheer weight of confirmatory evidence. He may raise the question whether due consideration has been attached to the subjective, and often unconscious, bias invariably operative in this field. The existence of these 'resistances' belongs to the most definitely demonstrated facts of human experience. Finally, he may in the last resort suggest that the critics make a first-hand investigation of the material, by which alone a final judgment can be passed. Short of this, one can only agree with the critic's objection that the findings of psychoanalysis tend to evoke a reaction of incredulity, but one should add that this fact—which incidentally is not the same as a criticism—was, together with the explanation of it, first pointed out by psychoanalysts themselves."

Dangers of Psychoanalysis (*a*) to Mental Health

Criticism.—Some critics maintain that in certain people a neurosis may be either created or made worse by psychoanalysis through the introspection it brings about.

Reply.—"The suggestion that introspection can cause a neurosis savors of the popular belief that nervous troubles are due to 'too much thinking about oneself'. Morbid introspection is surely a characteristic *symptom* of neurosis. This symptom is an important clue to the nature of neurosis in general, for it indicates that the subject is unduly attached to personal—usually intimate—thoughts and cannot get away from them to devote himself to the affairs of life. Release from this bondage is precisely what psychoanalysis effects. It does this by exploring the nature of the attachment in question and resolving it. A psychoanalysis would be considered a gross failure if any morbid or undue introspection persisted after the treatment. It is true that in some cases the tendency to introspection may be temporarily increased during the treatment, even outside the analytical hour, an effect which may be compared with the worsening of a patient's state immediately after a surgical operation, but as the analysis proceeds, the fruitless and circular type of introspection becomes replaced by an investigating and healthy introspection directed toward a definite goal, one which brings the whole morbid tendency to an end.

"Behind the idea of worsening a neurosis by psychoanalysis lies concealed a truth of another sort. The suggestion is probably based on the fact that an introspection induced by some one who attempts an analysis without the requisite training—or, more accurately, the emotional relationship subsisting between patient and physician—is apt to stimulate the sense of guilt present in every case of neurosis and hence to sharpen the underlying conflicts."

Dangers of Psychoanalysis (*b*) to Moral Health

Criticism.—Some critics hold that the directing of a patient's thoughts to sexual matters must be harmful morally; that any theory or practice of a system of psychology which considers the sex impulse as the strongest, if not the only, factor in the subconscious mental state, and one overriding all others in its influence on mental health, and which sees in most, if not all, abnormal conduct and pathological mental states the expression of a perverted sexuality, is fraught with very grave danger, especially in the young; that to unravel the tangled growth of the sexual life in an ill, sensitive, and suggestible adolescent must cause the most prejudicial changes in the whole outlook and manner of life of the boy or girl. The critic's fear of danger is based on the stress laid on sexuality in the writings of recognized psychoanalysts, the effect of which . . . is not in dispute.

Reply.—"If one has to take this criticism seriously, one is compelled to point out that, as is indicated by the one-sided and misleading allusion to psychoanalysis in its wording, and still more by the far stronger expressions and accusations which the Committee does not quote, the criticism is founded on a combination of ignorance and prejudice. If ever there was a subject that called for dispassionate study, it is surely that concerned with the sexual instinct and the tumultuous and complex problems it involves. The policy of flight from these problems, together

with the implied denunciation of those who try to face them objectively, is not only a confession of bankruptcy, but is the advocacy of an attitude which it is no longer possible to maintain now that the import and urgency of such problems are increasingly forced upon us. To those who do not close their eyes, the evidence is overwhelming that a vast amount of misery and mental ill health arises from abnormal development in this sphere and from the states of conflict which this brings in its train, especially in the young. I do not share the common suggestion that the medical profession, once enlightened, will not prove equal to the task of incorporating these difficult problems in its therapeutic obligations. Otherwise we should be committed to the irrational proposition that of all the systems of the body and mind the psycho-sexual system should alone be excluded from the fields of pathology and therapeutics.

"The special reference of the criticism to psychoanalysis is doubtless founded on the popular belief that this method of treatment encourages the patient to indulge in socially forbidden impulses, although all the alleged instances of this brought before the Committee were found to be devoid of foundation. Actually psychoanalysis consists in the restoration of an abnormal personality to normality, and under normality we include a higher standard of responsibility and self-control than usually prevails. I have never heard of any moral harm being done to a patient by psychoanalysis, but have ample experience of changes in an exactly opposite direction."

CONCLUSIONS

I. Psychoanalysis is a term now used in two ways: (1) in a loose popular sense hardly capable of description or definition, so wide is its extension; (2) in the strict sense of the technique devised by Freud, who first used the term, and the theory which he has built upon his work.

It is accordingly recognized that in any scientific inquiry into the matter, the claims of Freud and his followers to the use and definition of the term are just and must be respected.

II. It is recognized that there are workers and writers of repute in the field of psychology and psychopathology who use an exploratory therapy, but do not claim to be psychoanalysts, and indeed adopt some other descriptive term such as analytical psychology, individual psychology, deep mental analysis, etc.; and further, that there are practitioners of other methods of psychotherapy, hardly, if at all, connected with any recognized form of analytical teaching, to whom the term psychoanalyst is also often quite wrongly applied by the public. The Committee recognises that psychoanalysis should not be held responsible for the opinions or actions of those who are not in the proper sense psychoanalysts.

III. The Committee has recognized certain other misconceptions in relation to psychoanalysis, and has endeavored to remove them.

IV. The Committee finds that even among many of those most hostile to psychoanalysis there is a disposition to accept the existence of the unconscious mind as a reasonable hypothesis, though some prefer to use other terms to describe what is meant. Some members of the Committee, however, do not even go so far as this.

V. The Committee has set forth the most important of the criticisms of the theory and method of psychoanalysis, together with the answers of a recognized psychoanalyst thereto. It is of opinion that it is impossible

for the Committee to make any general pronouncement on questions of this nature.

VI. From the nature of the case the Committee has had no opportunity of testing psychoanalysis as a therapeutic method. It is, therefore, not in a position to express any collective opinion either in favor of the practice or in opposition to it. The claims of its advocates and the criticisms of those who oppose it must, as in other disputed issues, be tested by time, by experience, and by discussion.

American Bar Association Recommends Psychiatric Service for Courts and Penal Institutions

At the meeting of the American Bar Association in Memphis, in October, 1929, the chairman of the Section on Criminal Law and Criminology, Dean Justin Miller, of the University of Southern California Law School, presented a report on psychiatric service for courts and penal institutions which embodied the recommendations submitted to the Section by its Committee on Psychiatric Jurisprudence. These recommendations had been unanimously adopted by the Section, Dean Miller stated, and upon the presentation of his report, were unanimously adopted by the Bar Association. The report is given in full below.

Mr. President and Members of the Convention:

The work of your Section on Criminal Law and Criminology during the past year is reflected, in large measure, in the program of addresses delivered at the meetings on Tuesday. They ranged from intensive examinations of specific propositions to extensive consideration of problems of large magnitude. In the former group may be included discussion of:

1. "The Proposed Abolition of the Office of Coroner in the United States."
2. "The Procedure of Our Military Courts."
3. "Extreme Sentences for Offenses Mala Prohibita."

In the latter group were the following subjects:

1. "The Need for Uniform Reciprocal Criminal Law."
2. "Recent Activities of State Legislatures and Bar Associations in Connection with Crime."
3. "The Lawless Enforcement of Law."
4. "The Scientific Development of Criminal Law."

The members of the Section are particularly impressed with the fact that the development of our criminal law has been largely unscientific in character, largely the product of a method of trial and error; that much of it has come to us from an age when present scientific methods were unknown and now remains with us untested by the standards and critiques of to-day. We are impressed with the fact that the work of scientists in the fields of engineering, chemistry, physics, public health, and others, is meeting with almost universal respect and commendation, while the work of those in whose hands rests the building and administration of the criminal law is meeting with widespread condemnation.

We are anxious to secure for society the application of the best

methods of science to the solution of this problem. Several facts are obvious in this connection. In the first place, no short-lived, ephemeral, politically controlled commission can hope to parallel the work of the long-time, laboratory-conditioned scientific experiment. While crime commissions and law-enforcement commissions have their legitimate place in the scheme of things, their work can be little more than initiatory in character.

Even the work of restatement, such as that of the American Law Institute, admirably done, cannot be sufficient, for its end is largely determined by the law now in the books. What is needed is an intensive reëxamination, searching in character, of every principle of the criminal law, to determine whether our fathers, in the days of witchcraft, builded any more conclusively and definitely in the field of law than they did in medicine or engineering, to say nothing of many other fields of science unknown to our fathers and now able to contribute to the solution of our problem.

In order to get under way some preliminary thinking looking toward the establishment of research institutes and laboratories of the kind needed for this purpose, your Section, two years ago, asked and received your permission to establish joint, coöperating committees representing this Association and other responsible associations interested in the problem of crime. Pursuant to that authorization, coöperating committees have now been set up with the American Medical Association, the American Psychiatric Association, and the Social Science Research Council. Negotiations are under way with other organizations for the same purpose.

So far the most constructive work has been done by the joint committee of this Association and the American Psychiatric Association in studying the medico-legal problems which arise by reason of insanity and other mental defects. A report of this joint committee, approved also by the recently appointed committee of the American Medical Association, was presented at the meeting of your Section on Tuesday afternoon. This report, including certain resolutions, was adopted by the Section by unanimous vote.

The committee pointed out that the spectacular part of the field assigned to them—the part of chief interest to the man in the street, and of very great interest to us—is the contentious part, the part having to do with insanity problems arising in the actual trial of a criminal case. These problems are peculiarly difficult, and while the committee has had them under consideration for two years, it is not yet prepared to report upon them.

The report this year has to do only with those problems which are presented after a verdict or plea of guilty. Even as to this part of the field the action requested at this time is very modest in its nature. It does not attempt to go into details. It does not call for the enactment of legislation. It merely asks for a declaration of principle.

"Psychiatric service", as used in the committee's report, has reference to those techniques and arts and methods which diagnose the mental, nervous, and physical characteristics of the individual and, based upon facts developed by this diagnosis, recommend the modes of disposition and treatment which contain a promise of counteracting tendencies toward conduct which the law designates as antisocial. As so used, the

report suggests the desirability of having a psychiatric service available to criminal and juvenile courts and to penal and correctional institutions. It does not call for the accomplishment of this at once. There are not enough psychiatrists available. The report merely states that such psychiatric service is desirable. Furthermore, it does not concern itself with such matters as whether the psychiatric service should be, in its maintenance and control, state or local; whether the psychiatrist should be regularly attached to the court on a part-time or full-time basis or should be made available in some other way; or whether the psychiatrist should go to the prisoner, or the prisoner be sent to the psychiatrist.

The report suggests the desirability of having a psychiatric report filed in certain cases for the information of the judge or the board of parole. It does not even suggest that either the judge or the parole board should be bound by the report, but merely that he should have access to it.

The resolutions are as follows:

I. RESOLVED: That the American Bar Association go on record as stating the following matters to be desirable:

1. That there be available to every criminal and juvenile court a psychiatric service to assist the court in the disposition of offenders.
2. That no criminal be sentenced for any felony in any case in which the judge has any discretion as to the sentence until there be filed as a part of the record a psychiatric report.
3. That there be a psychiatric service available to every penal and correctional institution.
4. That there be a psychiatric report on every prisoner convicted of a felony before he is released.
5. That there be established in each state a complete system of administrative transfer and parole, and that there be no decision for or against any parole or any transfer from one institution to another without a psychiatric report.

II. RESOLVED by the American Bar Association that the various state and local associations be requested to give consideration to the recommendations in Resolution I, as a part of their programs during the coming year, and for this purpose to secure the coöperation of their respective state and local medical associations.

III. RESOLVED that the Committee on Psychiatric Jurisprudence be continued for further study of this field, in coöperation with committees from the American Psychiatric Association and the American Medical Association, and that it be empowered to adopt such means as in its judgment are best suited to effectuate the purpose of these resolutions.

Respectfully submitted,

JUSTIN MILLER
Chairman of the Section on
Criminal Law and Criminology

HOW LARGE SHOULD A STATE HOSPITAL BE?

Under the above title, the New York State Committee on Mental Hygiene of the State Charities Aid Association has recently issued in pamphlet form the report of a conference held at the Harvard Club,

New York City, on June 28, 1929, to discuss the question of the most desirable size for a state mental hospital. The conference, which was attended by a number of representative men in the mental-hospital field in New York and neighboring states, was informal in nature, the invitations having expressly stated that those who took part were not expected to speak in an official capacity, but to contribute the results of their own personal experience and observation.

As a starting point for the discussion, Mr. William E. Haugaard, State Commissioner of Architecture, outlined the plan of the proposed new Pilgrim State Hospital on Long Island, which is to accommodate approximately 8,800 patients in six units or groups. Mr. Haugaard explained the economies of construction and operation made possible by the plan, and Dr. Frederick W. Parsons, Commissioner of the New York State Department of Mental Hygiene, also spoke in its favor, stating that in his opinion the day was not far distant when a 10,000-bed hospital would be a necessity for the metropolitan district.

This led to a general discussion of the question whether, apart from considerations of economy, so large an institution is desirable from the medical point of view—whether the care and treatment of the individual patient—which, after all, as the chairman, Mr. Homer Folks, pointed out, is the main objective of the hospital—can be as successfully carried on as in a smaller hospital. On this point there was a very definite difference of opinion. On the one hand was the view—presented by Dr. Mortimer W. Raynor, Medical Director of Bloomingdale Hospital, and seconded by the majority of the group—that the atmosphere of a large hospital is unfavorable for psychiatric cases—that the patients tend to lose their individuality; that the close contact between doctor and patient so important in such cases is impossible; that the superintendent not only is out of touch with the patients, but is unable to maintain any close personal relationship with the hospital personnel. Even the greater economy of the larger hospital was questioned on the grounds that patients in larger groups tend to be more destructive, that fewer are discharged, and that the hospital property is less well cared for where the authority of the superintendent has to be widely delegated. True economy lies in the restoration to health of as large a number of patients as possible, and for this the small hospital, its advocates claimed, is better adapted than the large. On the other hand, Dr. William A. White, Superintendent of St. Elizabeths Hospital, Washington, speaking for the larger hospital, argued that the advantages claimed for the small hospital need not necessarily be sacrificed in the large. Delegation of authority is not in itself an evil; with the right kind of personnel,

it means that the hospital has at its service a group of experts, each a specialist in his own field, representing together an amount of skill and experience that it would be impossible for one man to acquire. But the building up of such a "high-powered" personnel requires not only money for adequate salaries, living quarters, and equipment, but opportunities for the kind of study and research that will appeal to first-class men. All these things the large hospital can provide at a relatively low per capita cost, while the per capita cost for the small hospital would be prohibitive.

No attempt was made to put the conference on record as either for or against the large hospital, but, as Mr. Folks notes in his Foreword to the report, "there was a marked preponderance of opinion in favor of the smaller hospital". It seemed to be fairly generally agreed "(1) that for the longer, or continued-treatment cases, as well as for the more acute ones, individualized medical and other care remains necessary; (2) that conditions involving primarily problems of personal readjustment cannot be met by impersonal methods; (3) that in any institution there is a trend toward impersonal methods, which increases with the size of the institution; (4) that this trend is inherent in the nature of institutions and is inevitable and irremovable; and while it may be measurably held in check by an alert and vigorous medical director who has succeeded in selecting a like-minded staff, medical and other, yet on the least relaxation of vigilance and effort, it resumes its normal trend to tradition and impersonality".

As one of the most constructive suggestions brought out by the conference, Mr. Folks cites the statement of Dr. George M. Kline, Commissioner of the Massachusetts Department of Mental Diseases, that "in Massachusetts, as a result of deliberate effort and through the work of an adequate and qualified staff of social workers supervised by an expert at headquarters, not less than one-fifth of all the insane under commitment are back in their communities on parole, working out their problems of personal, social, and economic readjustment under social and medical supervision and assistance, and costing the state only for such supervision. Should it be practicable in New York to achieve such a result, the resulting saving would be literally millions each year."

Those who attended the conference were: Hon. Herbert H. Lehman, Lieutenant Governor, Albany, N. Y.; Hon. Eberly Hutchinson, Chairman, Assembly Ways and Means Committee, Albany, N. Y.; Mr. George F. Canfield, President, State Charities Aid Association, New York City; Dr. Frederick W. Parsons, Commissioner, New York State Department of Mental Hygiene, Albany, N. Y.; Mr. William E.

Haugaard, Commissioner of Architecture, Albany, N. Y.; Dr. George M. Kline, Commissioner, Massachusetts Department of Mental Diseases, Boston, Mass.; Dr. William C. Sandy, Director Bureau of Mental Health, Pennsylvania Department of Welfare, Harrisburg, Pa.; Dr. William A. White, Medical Superintendent, St. Elizabeths Hospital, Washington, D. C.; Dr. C. Macfie Campbell, Medical Director, Boston Psychopathic Hospital, Boston, Mass.; Dr. William L. Russell, General Psychiatric Director, Bloomingdale Hospital, White Plains, N. Y.; Dr. Mortimer W. Raynor, Medical Director, Bloomingdale Hospital, White Plains, N. Y.; Dr. A. A. Brill, New York City; Dr. Samuel W. Hamilton, Director, Division on Hospital Service, National Committee for Mental Hygiene, New York City; Dr. George H. Kirby, Director, New York State Psychiatric Institute and Hospital, New York City; Dr. C. Floyd Haviland, Medical Superintendent, Manhattan State Hospital, Ward's Island, N. Y.; Dr. William C. Garvin, Medical Superintendent, Binghamton State Hospital, Binghamton, N. Y.; Dr. Clarence O. Cheney, Medical Superintendent, Hudson River State Hospital, Poughkeepsie, N. Y.; Mr. Joseph H. Wilson, Director, Division of the Budget, Albany, N. Y.; Mr. Mason C. Hutchins, Secretary, Senate Finance Committee, representing Hon. Charles J. Hewitt, Chairman of that Committee, Albany, N. Y.; Mr. Lewis M. Farrington, Secretary, State Department of Mental Hygiene, Albany, N. Y.; Mr. George R. Wadsworth, Department of Correction, Albany, N. Y. (formerly of the State Architect's staff); Mr. R. J. Foster, Assistant to State Commissioner of Architecture, Albany, N. Y.; Dr. Vernon C. Branham, Medical Director, New York State Committee on Mental Hygiene, State Charities Aid Association, New York City; Mr. Stanley P. Davies, Assistant Secretary, State Charities Aid Association, New York City.

A Mental-Hygiene Commission for Soviet Russia

The People's Commissariat of Public Health of the Russian Socialist Federated Soviet Republic has announced the organization of a mental-hygiene commission, whose work will be carried on in connection with the Moscow State Neuropsychiatric Dispensary. A translation of the announcement, by Dr. Meyer K. Amdur, of the United States Veterans' Hospital, Perry's Point, Maryland, is given below.

> In view of the growth of the mental-hygiene movement all over the world and the clearly-defined trend of Soviet psychoneurology toward the prevention of nervous and mental disorders, special emphasis must be placed upon this aspect of our neuropsychiatric work. Originating in the United States of America not long before the World War, the mental-hygiene movement has since then achieved great success not only in

America—where the whole subject of psychiatry is being rebuilt on a mental-hygiene basis—but in most of the countries of Western Europe. The idea of mental hygiene as the only possible method of struggling successfully against neuropsychiatric disorders is being ever more strongly emphasized in those countries in which psychiatrists still have to struggle with antiquated legal concepts of insanity.

We in the Union of Soviet Socialist Republics have every opportunity for developing a powerful mental-hygiene movement in connection with our efforts to build a socially new man. Physicians—neuropathologists and psychiatrists—and mental hygienists will occupy an important place in the forefront of the cultural revolution, to insure a sound basis of health for the psychophysical organism of the new man.

Much is already being done in this field—individual physicians, neuropathologists, and psychiatrists are carrying on mental-hygiene work in dispensaries, scientific institutions, schools, prisons, and so forth—but the movement has not yet been fully developed. In order to record, explain, and direct this work—in order to acquaint the masses with the methods, problems, and achievements of the mental-hygiene movement—the Commissariat of Public Health of the Russian Socialist Federated Soviet Republic has established at the Moscow State Neuropsychiatric Dispensary (at present the Scientific Institute of Neuropsychiatric Prophylaxis) a mental-hygiene commission, which will endeavor to organize and unify all the mental-hygiene work in the Republic. Such committees or leagues for mental hygiene have been organized abroad in other countries, and plans have been made for the First International Congress on Mental Hygiene, to be held in Washington, D. C., in 1930.

The commission will issue at periodical intervals a series of booklets, to be entitled "Mental Hygiene", which later will take the form of a magazine. Contributions are invited from local workers—physicians, neuropathologists, psychiatrists, narcologists, pediatrists, psychophysiologists, psychotechnicians, social hygienists, and so forth.

For the first issue, which will appear this autumn [1929] and which will contain a number of informative and instructive articles, the commission would like to secure data from the various localities on the following points:

1. What is the status of your section in regard to the organization of hospital and other facilities for the care of nervous and mental patients?

2. Do the physicians, neuropathologists, and psychiatrists carry on mental-hygiene work of a constructive and preventive nature among the population, in schools, hospitals, prisons, among professional groups, among children, in industry, etc.?

3. What part do neuropathologists and psychiatrists take in the struggle against occupational diseases and social diseases (such as alcoholism, drug addiction, crime, prostitution, etc.)

4. What part is played by neuropathologists and psychiatrists in peasants' and workingmen's social organizations, in the public-health sections of local soviets, in the public-health units of individual enterprises, in commissions for the protection of labor, for the sanitation of industry, of home life, etc.

5. What investigations of individual enterprises, groups of the population, and so forth have been carried on in your section by neuropatholo-

gists and psychiatrists, with the idea of establishing dispensaries, studying professional ills, or for other purposes?

6. Are there in your section any general physicians, neuropathologists, or psychiatrists, working in the direction of mental hygiene, who can and desire to work actively in that field, particularly in the way of organizing a local mental-hygiene commission, which would be connected with the Moscow commission?

We will greatly appreciate an early communication of this information, which we need in order to give a complete picture of local conditions in the first number of *Mental Hygiene* and, more important still, to serve as a basis for the further organization of our young mental-hygiene movement.

Chairman of Mental Hygiene Commission (signed) L. M. ROSENSHEIN.
Secretary (signed) A. M. RAPOPORT.

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